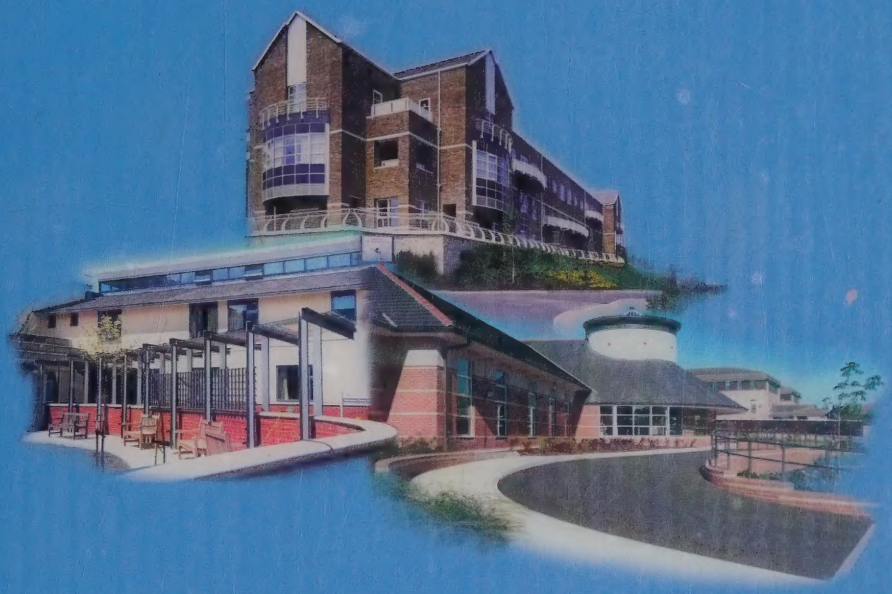
MC0331

Developing an estate strategy



Modernising the NHS

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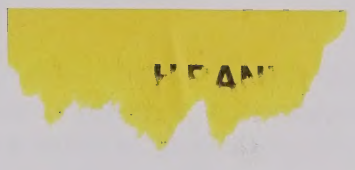
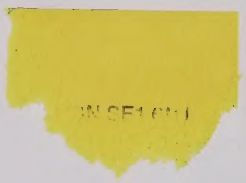
Developing an estate strategy





Modernising the NHS

NHS Executive

NHS Estates
An Executive Agency of the Department of Health

- 1 MAR 2000

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Executive summary

To deliver a modern NHS, fit for the 21st century, buildings and equipment are required that are in the right place, in the right condition, of the right type and which will be able to respond to future service needs.

A well-thought-out estate strategy is a prerequisite to ensuring that there are high-quality, well-located buildings, which are giving best value in facilitating the delivery of modern patient care services.

All NHS trusts, including Primary Care Trusts (PCTs), have a statutory responsibility for the management of their assets. The guidance in this document is directed at senior managers who have responsibilities for the stewardship of the estate.

The document is designed to help you develop a robust estate strategy. It is set out in three parts: the context within the NHS; what can be achieved through a best in class estate strategy; and how to develop your estate strategy.

The document does not intend to give a standardised format. Individual strategies will be based on differing local circumstances. The case studies contained in Appendix 4 are designed to show how elements of a strategy can be put together and to demonstrate the steps that can be taken to improve performance.

'Developing an estate strategy' complements two other key documents: 'Estatecode', which includes a section on property appraisal – assessing the state of the existing asset base, and the 'Capital Investment Manual' which sets out the process for procuring new capital assets. This document should, therefore, be read in the context of the other two.

Trusts and health authorities are encouraged to use this guidance as a starting point and to build upon its ideas and principles in producing their own strategies.

Estate strategy

Quality checklist

- 1 MAR 2000

To assist in developing a meaningful estate strategy, a quality checklist (illustrated opposite) has been developed by Regional Offices, to be used in discussion and agreement with trusts, as a means of determining the key criteria that constitute an estate strategy.

The checklist itemises the various components that make up an estate strategy. Most of these components are judged to be critical while others are considered to be highly desirable but not critical. If any of the critical components are missing or are so poorly produced as to be unacceptable, then the trust would not be judged to have an estate strategy.

The quality of the components can be rated on a simple A, B, C, F rating system:

A = Excellent

C = Acceptable

B = Good

F = Unacceptable.

Using these scores, trusts will be better placed to concentrate their efforts in the areas that most require improvement. The target for all trusts to aim for is to have estate strategies which have the rating of 'A'.

For further information contact the Head of Estates and Facilities at your Regional Office.

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Quality checklist

Key components of an estate strategy:	QUALITY RATING			
	A	B	C	F
GENERAL:				
Based upon an approved service strategy				
Reflects the requirements of the HImP *				
Contained within one document				
Appropriate Board approvals / Director approvals				
Mechanisms for regular review				
Copy lodged with RO				
WHERE ARE WE NOW:				
Trust existing estate description:				
– Physical condition				
– Energy efficiency				
– Statutory compliance				
– Functional suitability				
– Space utilisation				
Controls assurance review				
Environmental impact assessment				
Cost to Condition B (Backlog)				
Estate running costs (hard FM)				
Occupancy costs (including capital charges, rates, soft FM)				
Current estate value				
Summary of priorities				
WHERE DO WE WANT TO BE:				
Summary of the implications of the Service Strategy upon the estate				
Implications of the effect of Structure and Local Plans				
Environmental Action Plan				
Estate performance targets				
HOW DO WE GET THERE:				
Strategic options for estate change				
Capital investment programme				
Summary disposal and proceeds of sale				
Site-based development control plans				
Forecast effect of strategy on estate performance				
Forecast effect of environmental performance improvements				
Controls assurance action plan				

KEY: Bold / Red = Critical
A = EXCELLENT B = GOOD C = ACCEPTABLE F = UNACCEPTABLE

Any trust with F rating for a critical element does not have an estate strategy.

* Health Improvement Programme

Cancer treatment
Photograph © Roger Hutchings

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Maternity
Photograph © Mike Goldwater

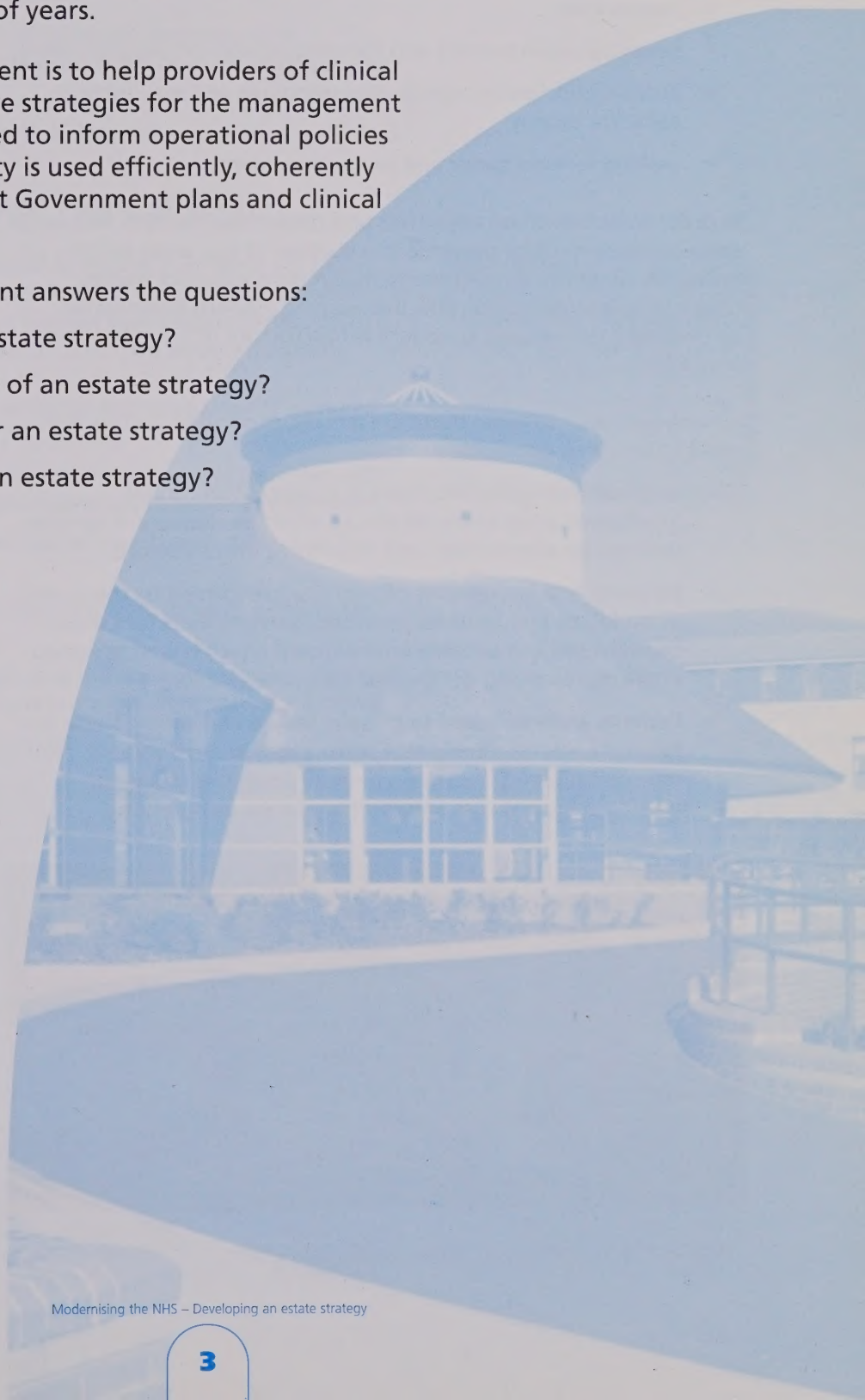
Introduction

The NHS estate is one of the largest and most complex property portfolios in Europe. It contains a range of buildings, from the most up to date hospitals and primary care facilities, designed specifically to meet the demands of modern and future healthcare, to hospitals which can trace their roots back hundreds of years.

The purpose of this document is to help providers of clinical services to develop effective strategies for the management of their estate. It is intended to inform operational policies to ensure that NHS property is used efficiently, coherently and strategically to support Government plans and clinical needs.

This section of the document answers the questions:

- Why do we need an estate strategy?
- What are the benefits of an estate strategy?
- Who is responsible for an estate strategy?
- How do we develop an estate strategy?



Why do we need an estate strategy?

The Government's overall aim for the Department of Health is to improve the health and well-being of the population through the resources available. As stated in the 1999 'Capital Investment Strategy for the Department of Health', the Government is determined to modernise health and social services and has developed a clear, linked set of policies to do so by:

- tackling the root causes of ill health and cutting health inequalities;
- breaking down barriers and focusing services on people's needs;
- ensuring uniformly high quality standards and maximising value for money;
- making services faster and more convenient.

In order to deliver these objectives and modernise the NHS and social services, there must be progress in a number of key areas which underpin all service development: maximising value for money; developing and involving staff; introducing modern information systems; and developing a modern infrastructure of buildings and equipment.

As well as these key areas there are a number of other factors that need to be taken into account:

- In modernising the NHS there is a substantive capital investment programme to ensure effective delivery of services through an appropriate and responsive infrastructure.
- Patients' first impressions of a service are formed by the quality of buildings and facilities provided. Services therefore should be delivered in a suitable environment which is well designed while representing good value for money.
- Patients and staff need to be safe, secure and warm. These are fundamental requirements for the physical environment. Not only do buildings impact on patient perception, they can provide a holistic care environment by ensuring good

Information

The 1999 Department of Health document 'Capital Investment Strategy for the Department of Health' aims to support the modernisation of the NHS "through enabling capital resources to be effectively deployed to deliver the aims and objectives of the NHS". It describes the historical context and current size of the NHS estate, outlines the service vision and the current Ministerial priorities for capital investment.
The document refers to the variable condition of the estate and the continued high backlog maintenance bill.
The estate implications of developments in primary care and community services are assessed as well as the implications of shorter lengths of stay in acute general hospitals.
The importance of fairness in allocating capital resources is being improved through national prioritisation of major projects, use of the Health Improvement Programmes and the activities of the Health Action Zones.
The document also stresses the role of capital in improving the quality and safety of the healthcare environment, and in promoting environmentally friendly policies.

Montpelier Health Centre
Architect: Vic Love Architects. Photographer: Mark Bolton

functionality, meeting expectations in terms of privacy and dignity, providing good access for all, reducing infection and minimising accidents.

- The NHS has one of the largest property portfolios in Europe with a current use value of about £23bn and a significantly greater replacement value.
- Approximately 20% of a trust's annual income is spent on its infrastructure. This is a significant financial commitment which needs to be managed effectively.
- Health authorities in their local Health Improvement Programmes (HImPs) will be expected to include a supporting estate plan.

In this context the development of an effective estate strategy is vital.

What are the benefits of an estate strategy?

A robust estate strategy is essential to ensure that there are high-quality, well-located buildings which are in the right condition to facilitate the delivery of modern patient care services. Without an estate strategy, capital investments cannot be made effectively.

The benefits to a trust and the wider health economy of having a formal estate strategy include the provision of:

- an assurance that the quality of clinical services provided will be supported by a safe, secure and appropriate environment;
- a method of ensuring that capital investments reflect service strategies and plans;
- a plan for change that enables progress towards goals to be measured;
- a strategic context in which detailed business cases for all capital investment can be developed and evaluated, however funded;

Information

The White Paper 'The New NHS: Modern • Dependable' sets out a new role for health authorities and places greater emphasis on joint working and strategy setting.

Controls assurance

HSC 1999/123 identifies the "system of internal control" in most NHS organisations as having three distinct control sub-systems: financial, organisational and clinical. It requires NHS trusts and health authorities to move beyond annual reporting on internal financial controls and to include reports on wider risk management and organisational controls.

Under HSC 1999/123, all NHS trusts and health authorities (including Special Health Authorities) will have a designated executive director who has overall responsibility for ensuring the implementation of controls assurance covering risk management and organisational controls, and for reporting to the board.

The minimum requirements on NHS trusts and health authorities are, in accordance with the guidance contained in HSC 1999/123, to:

- *ensure that the appropriate structures are in place within their organisation for implementing controls assurance, taking account of linkages with clinical governance and, where applicable, NHS risk-pooling schemes;*
- *from October 1999, conduct a baseline self-assessment of compliance with risk management and organisational control standards;*
- *formulate a prioritised action plan with clearly assigned responsibilities in the light of this assessment;*
- *provide an assurance statement within their Annual Report; and*
- *ensure appropriate arrangements are in place to verify the assurance statement.*

- a clear statement by a trust to the public and staff that it has positive plans to maintain and improve services and facilities;
- a means by which a health authority can identify capital investment projects which will require its formal approval and a link to its HImP;
- a clear commitment to complying with sustainable development and environmental requirements and initiatives;
- an assurance that asset management costs are appropriate, and that future investment is effectively targeted;
- assurance that risks are controlled and that investment is properly targeted to reduce risk;
- a clear commitment that surplus assets are and will be identified over time, and will be either disposed of or used for future service needs.

Who is responsible for the estate strategy?

NHS trusts have a statutory responsibility for the management of their assets; the guidance in this document 'Developing an estate strategy' is directed primarily at senior managers in NHS trusts. Primary Care Trusts (PCTs) will also be expected to develop their own estate strategies. Trust chief executives will need to ensure that responsibility for the production of their estate strategy is clearly assigned to a senior manager, probably the estates director. It will, however, be important to ensure that the strategy is considered and approved by the whole of the trust board. It will need to be reviewed at least annually.

Health authorities will need to set top-level targets for the performance of the estate of trusts and other organisations from whom they purchase services.

In addition, where major capital investment projects may result, the health authority and the Regional Office will need to approve the strategic outline case and the subsequent business case. The NHS Estates team will review each estate strategy and can provide guidance and advice to anyone preparing one.

How do we develop an estate strategy?

This document is designed to help you develop a robust estate strategy. It is set out in three parts as follows:

Section one: The context within the NHS

Section two: What can be achieved through a best in class estate strategy?

Section three: How to develop your estate strategy

This document does not intend to give a standardised format for the content of an estate strategy. Individual strategies will be based on differing local circumstances. However, trusts are encouraged to use this guidance as a starting point and to build upon the ideas and principles set out in the following pages.

Notes

Appendix 1 contains information on how to use estate performance indicators.

Appendix 2 outlines the NHS Estates Quality Assurance Model (The Patient Journey) Toolkit for patient facilities.

Appendix 3 gives useful examples of tables that can be used in the estate strategy.

Appendix 4 gives case studies of estate strategies from an acute trust and a community trust.

Section one: The context within the NHS

This section of the document explains the following:

- The pressure for change and modernisation
- The need for comprehensive planning

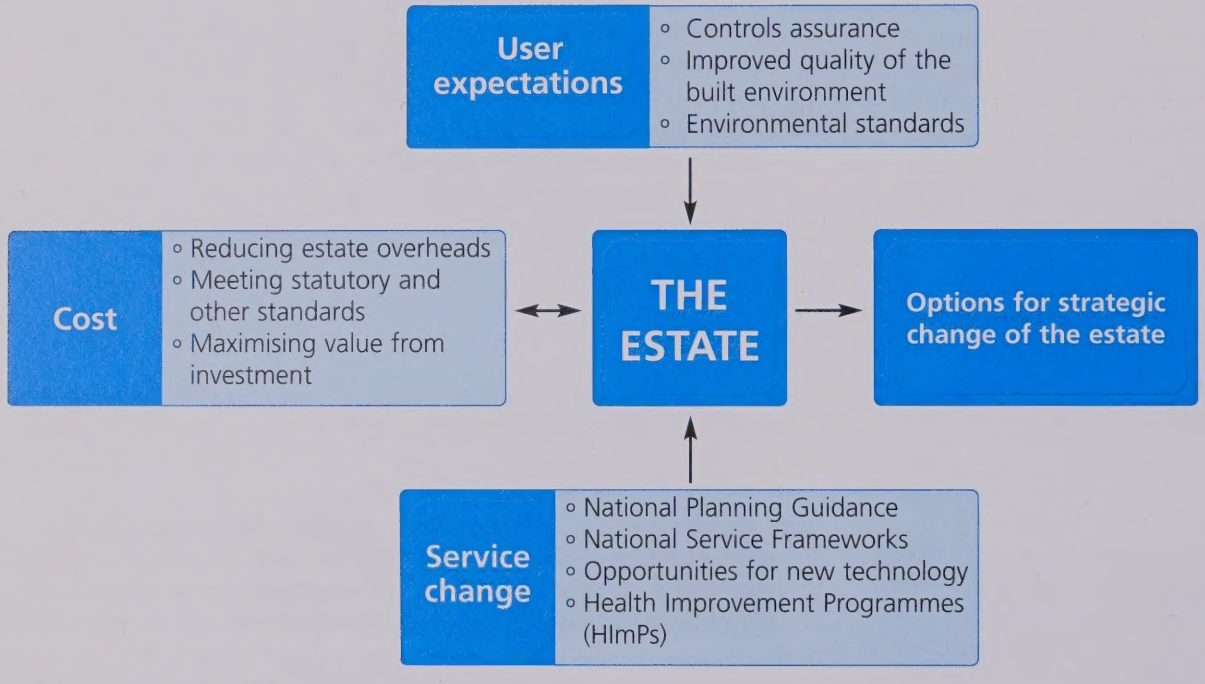
It also points out the need for estate strategies within Primary Care Trusts (PCTs); as a framework within which procurement proposals can be developed and evaluated for public/private partnerships; and as a starting point for the implementation of performance management.

The pressure for change and modernisation

"Modern health services should reflect patients' needs. They need to provide fast, convenient, high quality services. They need to work with other parts of the local health and social care systems to offer truly integrated services to patients. They need to be flexible in their approach and demonstrate the capacity to change as technology and demography change."
'Capital Investment Strategy', Department of Health, 1999

It is vital that the estate is able to respond to these changes in the most timely, effective and economic way possible, whilst optimising patient care. Effective strategic estate planning and management provides an opportunity to facilitate such change.

Figure 1 Pressures for change



A new era for health building is emerging with emphasis on greater efficiency and more consumer responsiveness. Patients will undoubtedly wish to have a voice in the way they receive care and treatment, and the setting in which they receive it. Opportunities arise for more flexible and imaginative use of buildings: for example, using multi-purpose public and private buildings for health education, disease screening and patient support groups, and leasing community facilities.

The increase in day surgery, shorter length of stay and bed turnover all impact on the future provision of the estate, as will the growth of primary care and intermediate care facilities.

A need for comprehensive planning

Initiatives to modernise the NHS have given renewed emphasis to coherent service planning which considers the needs of the wider health economy. This should be reflected in local Health Improvement Programmes (HImPs), the scope of which will encompass all the issues shown in Figure 2. The formulation of HImPs requires the introduction of new skills in health authorities and a new approach to service planning within NHS trusts.

Whilst it is correct that the estate strategy will be planned jointly or follow the development of service plans for the wider health economy, in practice the process is an iterative one. In other words, the condition, cost and appropriateness of the estate should be one of the key factors taken into account by a health authority and trusts in producing individual service strategies and the health improvement programme as a whole. This is reflected in HSC 1998/167 which states that HImPs should include a Service and Financial Framework for the NHS, setting out in broad terms how resources are to be allocated to meet national and related local priorities, responding to the NHS Modernisation Fund targets and planning for the location, investment and configuration of services to meet local needs.

Why risk management?

An organisation and its patients and staff are put at risk when things go wrong. There are different levels of risk depending upon the likelihood of something going wrong, the seriousness of the incident, and the consequences arising from it.

Every NHS employee needs to be aware of risks that can result in serious consequences for themselves, colleagues, patients or the organisation. All staff need to know how to recognise potential problems, how to assess their impact, and how to put them right.

Historically, the management of risk has often been seen as the responsibility of one person in the organisation – the risk manager. Controls assurance assumes that control of risk is part of the work of everyone involved in the provision of healthcare.

When the likelihood and consequences of risks are analysed and found to be serious, putting lives in danger, opening up threats of litigation, harming staff or patients, or damaging the reputation of the organisation staff need to be able to alert colleagues and managers to assess the need for rapid action. Where risks are analysed and found to be not as serious, staff need to be able to devise action plans which will manage the risk and improve the quality of healthcare provided to patients.

Controls assurance provides a framework which can be used across the whole of every NHS organisation to identify problems, assess risk and determine actions to reduce or eliminate risk.

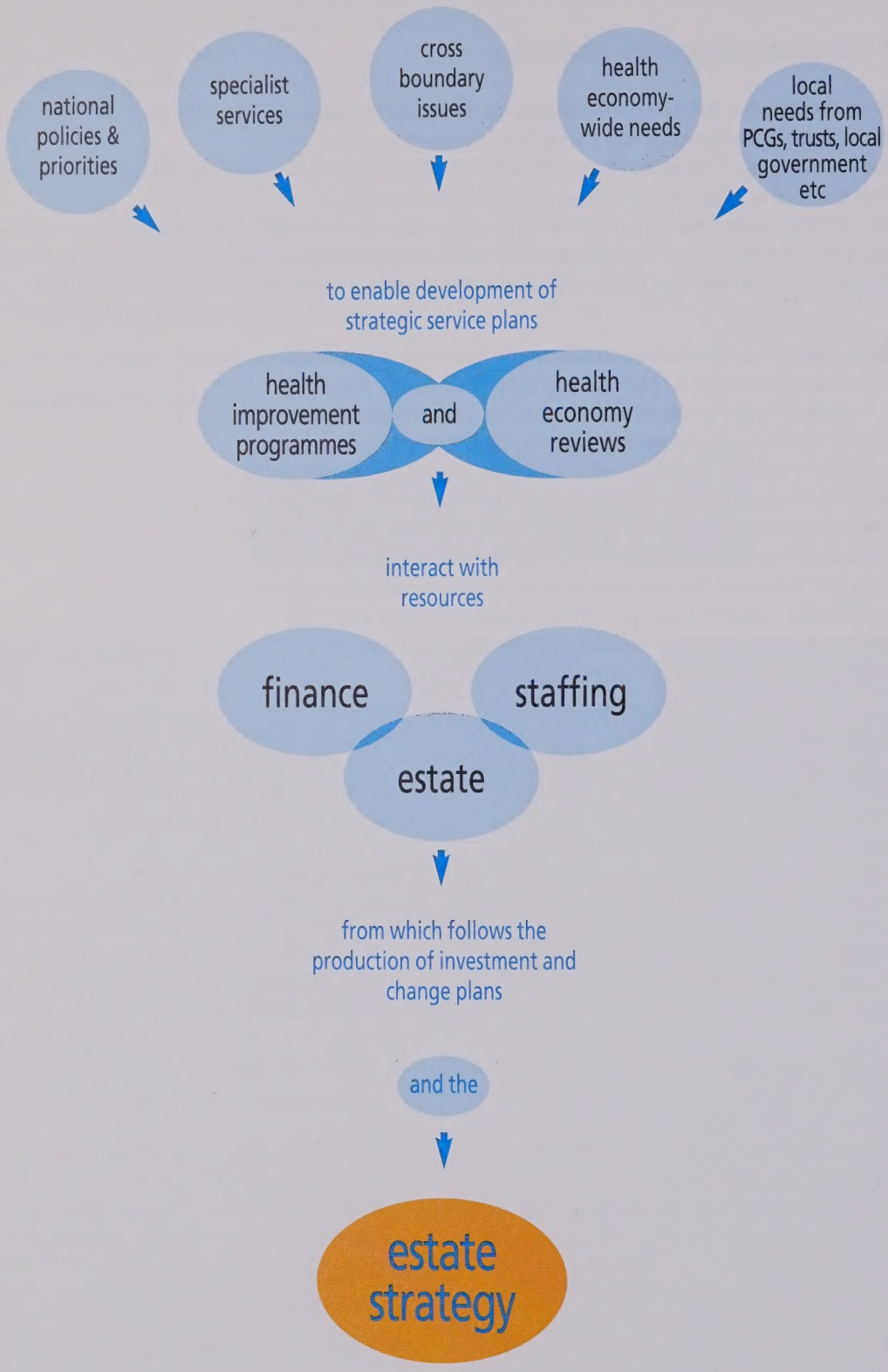
What is a 'significant risk'?

Significant risks can be defined as risks that are significant to the fulfilment of the organisation's objectives. The controls assurance standards reflect key areas where significant risks can be found, which could pose a threat to fulfilling the organisation's objectives. Areas that might generate 'significant risk' include:

- *management of the estate;*
- *fire safety;*
- *managing medical devices;*
- *health and safety;*
- *controlling contractors;*
- *infection control;*
- *waste management;*
- *information management and technology;*
- *security.*

It is the responsibility of individual organisations to establish areas of significant risk and to prepare a prioritised action plan.

Figure 2 The strategic planning process



As the 1997 White Paper, 'The New NHS: Modern • Dependable' makes clear, making decisions on strategic and service developments will require close partnership working between health authorities, PCGs/PCTs and local NHS trusts. The estate strategy for each trust cannot, therefore, be developed or viewed in isolation from the wider health economy and will increasingly need to take account of service changes across a wider area. The interaction between health and social care will also require account to be taken of local authorities' strategies.

Primary Care Trusts (PCTs)

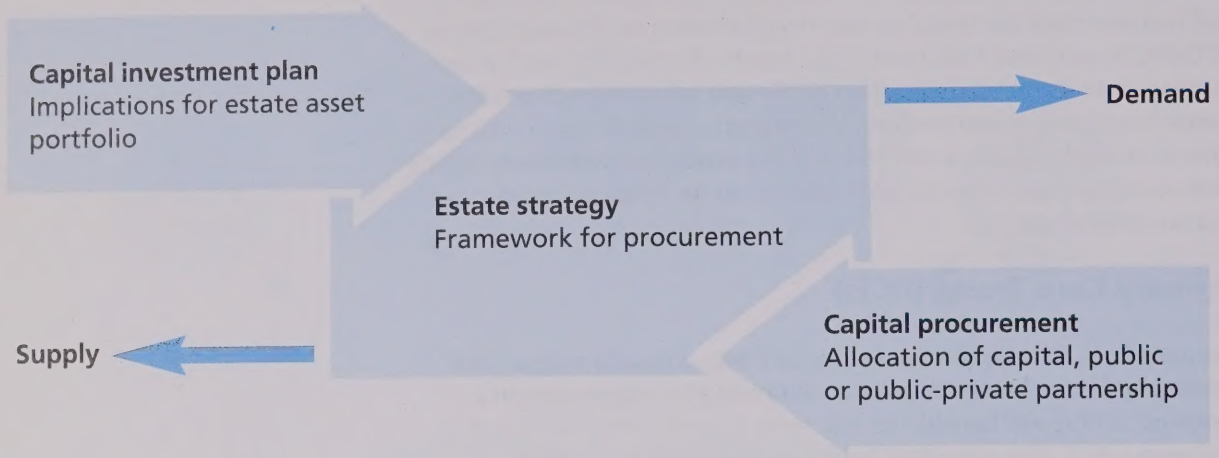
Primary Care Groups (PCGs), in the context of health authorities' HImPs, will have an active role in planning and commissioning services. A PCG will be able to join with a community NHS trust to become a PCT. This new NHS body will have responsibility for both commissioning and delivering services. Health authorities will need therefore to ensure that estate strategies agreed under the Primary Care Investment Plan are consistent with the likely service strategies of the PCT.

Public–private partnerships

Estate strategies must fully outline service need in order to deliver an effective built environment to support patient care. The supply of assets must be aligned with need (see Figure 3 overleaf). New capital investments may be delivered through public sector routes or through public–private partnerships (PPPs). An estate strategy will provide an essential framework within which procurement proposals can be developed and evaluated. The strategy therefore must be recognised both as an essential precursor to the allocation of capital and as an integral part of the procurement process. For major capital schemes, it will form one component of the Strategic Outline Case. With current pressures on the allocation of capital, it is unlikely that investment proposals will be approved in the absence of a comprehensive and up-to-date estate strategy.

The PPP initiative demands an emphasis on outputs. In other words, it requires a clear specification of what any capital investment should achieve in terms of service delivery, environmental and maintenance standards. An estate strategy provides an accepted baseline of performance standards for the estate which can be used to inform the development of PPP schemes. Capital investment schemes are increasingly being targeted to achieve specific improvements in the NHS estate, for example the impact on patients, improved quality, increased compliance with statutory and non-statutory standards for fire, health and safety, meeting the requirement of the Disability Discrimination Act, and single sex accommodation targets. The estate strategy must demonstrate the priority given to these requirements.

Figure 3 Aligning supply of estate assets with demand



Performance management

An estate strategy is a starting point for the implementation of performance management measures to improve the performance and utilisation of the estate. In this, consideration will need to be given to procurement and disposal issues as well as operational issues.

An analysis of the estate, as the first step in the development of an estate strategy, will provide a "snapshot" of how the estate is performing. Comparing the performance of similar trusts to regional and national averages allows the identification and targeting of areas where performance should be improved. This is particularly relevant to determining whether the service is operating from a larger than average site. It also enables more effective prioritisation, allocation and targeting of resources and management effort to secure improvements. Options to improve estate performance across the trust can be explored, and the impact of new service strategies assessed. Estate planning offers an opportunity to release resources tied up in poorly utilised land and buildings which can be re-invested in patient care and improving the building stock.

Information

Estates Returns Information Collection – ERIC – consists of the national analysis of estate information collected via the estates tables of the Trust Financial Proformas (TFPs) from all NHS trusts in England.
The ERIC software tool is distributed to all trusts to collect the data and to give feedback on the previous year's national data set. It is a mandatory requirement for trusts to submit an estates information return to provide an overview of the estate in the NHS.
A set of performance indicators to measure the performance of a trust's estate has now been developed and issued to all trusts (see Appendix 1).
ERIC helpline: 0113 254 7000
For more information visit the NHS Estates website:

www.nhsestates.gov.uk

Jubilee Building at Leeds General Infirmary.
Architects: Llewelyn Davies
Photographer: Matthew Weinreb

Patients' perception of the environment

Healthcare buildings should provide safe, stable and predictable environments which enable better care and treatment of patients. From entering the site, the first impressions of the physical appearance and layout of the healthcare facility are important because they influence the behaviour of all the people who use it: patients, staff and visitors. As well as affecting physical comfort, the environment also transmits meaning. What patients and visitors see, hear, and smell blend into one image. A physical environment that supports the psychological needs of patients and visitors will be considered a positive caring environment. On the other hand, physical arrangements that make the visitor or patient feel unimportant, or even forgotten, send negative messages and will increase levels of anxiety.

Quality Assurance Model

To assist trusts in identifying those areas which require improvement NHS Estates has devised a toolkit for assessing the quality of the patient environment. Originally designed for assessing accident and emergency departments the toolkit can be adapted for use in other patient areas. The toolkit uses patient surveys to give high-level indications of people's satisfaction in thirteen main categories. It is

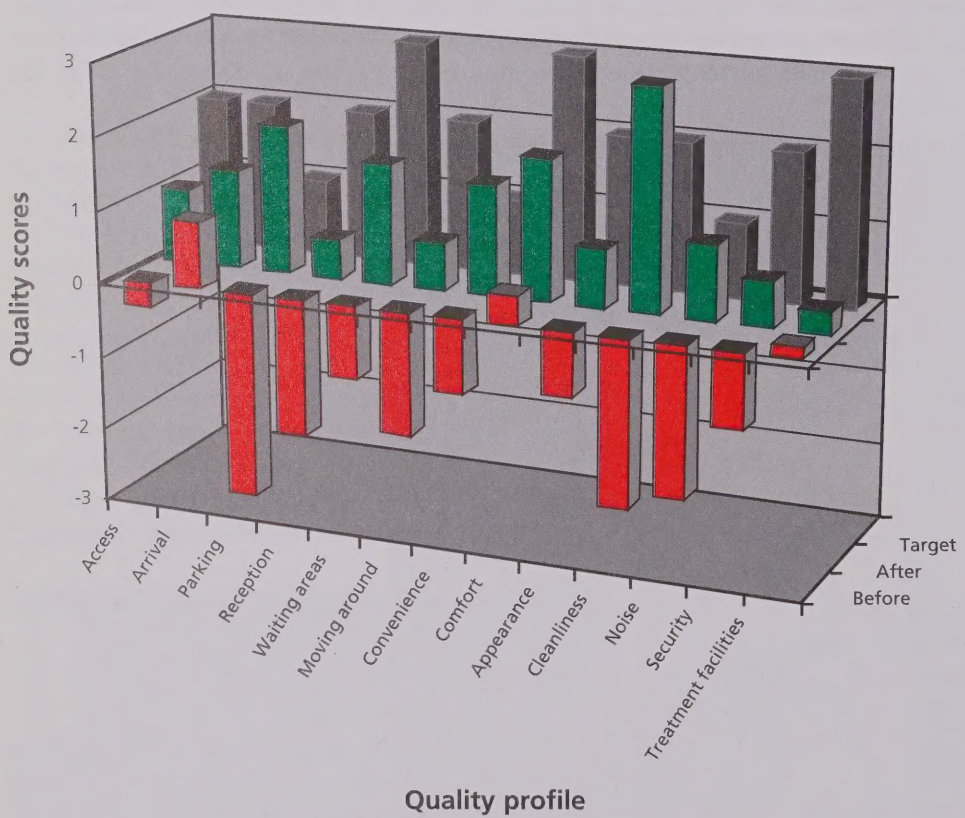
Hillingdon: Accident and Emergency Department, Childrens Play Area.
Architect: Nightingale Associates
Photographer: Charlotte Wood

designed to be used twice: firstly, before a scheme for upgrading has been devised; secondly, after that same scheme has been completed, where it can be used to obtain feedback which is directly comparable with the first survey. The toolkit can also be used to set targets that can be viewed alongside the before and after survey results (see Figure 4 below).

The figure shows three sets of data (before, after and targets) merged into a three-dimensional chart, in order to allow comparisons to be made between them. This enhances understanding and allows analysis of the quality profiles, as compared to the agreed performance targets.

For further information see Appendix 2.

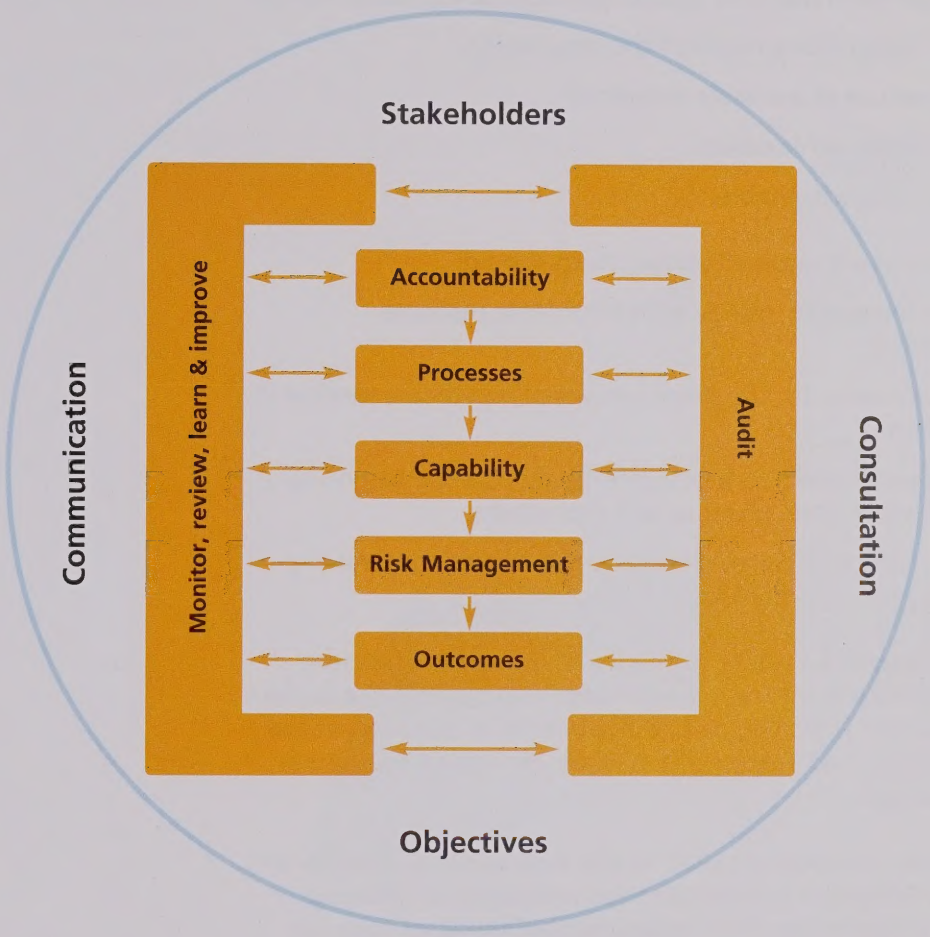
Figure 4 NHS Estates Quality Assurance Model (The Patient Journey)
A toolkit for patient facilities



A management model for controls assurance

Controls assurance is a crucial aspect of perfomance management. In an effort to clarify the management philosophy underpinning controls assurance, and to assist with construction of the controls assurance standards, the figure below presents a 'model of internal control'.

Figure 5 Model of control



The model indicates that, in pursuit of meeting an organisation's objectives, the desired outcomes for any area of activity can be obtained by:

- *establishing appropriate accountability structures (leadership, responsible people, committees, reporting arrangements, policies and strategies, etc.);*
- *ensuring that the core processes required to produce the desired outcomes are in place and working properly;*
- *having the necessary capability (information, knowledge, skills and resources) to ensure the system operates effectively;*
- *applying risk management to help ensure that all risks which could, potentially, threaten the ability of the organisation to meet any or all of its objectives are systematically identified, assessed and treated;*

and, in addition, by:

- *ensuring that an independent audit of the system of internal control is carried out to help establish adequacy and effectiveness;*
- *management and the board monitoring and reviewing the system in order to ensure that it is working effectively and to learn and, where necessary, improve the system; and*
- *promoting continuous and effective communication and consultation with stakeholders.*

Conclusion

The estate strategy for an individual trust could be based on an integrated HImP created by the health authority on the basis of the wider health economy, and should be consistent with the direction set by the NHS Executive. Alternatively, the estate strategy could be based on service analysis by a trust to define its longer-term future, working within the known plans of the health authority. In either case, the longer-term plans for health services and the estate should:

- meet the healthcare needs of the population;
- make best use of available resources;
- be technically achievable;
- be financially affordable.

In meeting the needs outlined above, trusts should:

- prepare an estate strategy with affordable resource implications;
- examine models for the development of healthcare services in all settings;
- match capital assets to healthcare developments, balancing realistic achievable solutions and aspirations;
- take account of investment required in all settings, and any shifts in revenue resources.

The development of an estate strategy is a complex process that must reflect service need and the foreseeable changes in the pattern of service delivery. However, due account needs to be taken of the existing asset base and infrastructure which cannot be adapted or replaced overnight.

Estate strategies are vital to trusts, health authorities and Regional Offices in ensuring that full and planned consideration is being given to the effective use and management of the asset base in providing better healthcare.

Chiddenbrook Surgery, Devon
Architect: Smith Roberts Associates. Photographer: Christopher Bland

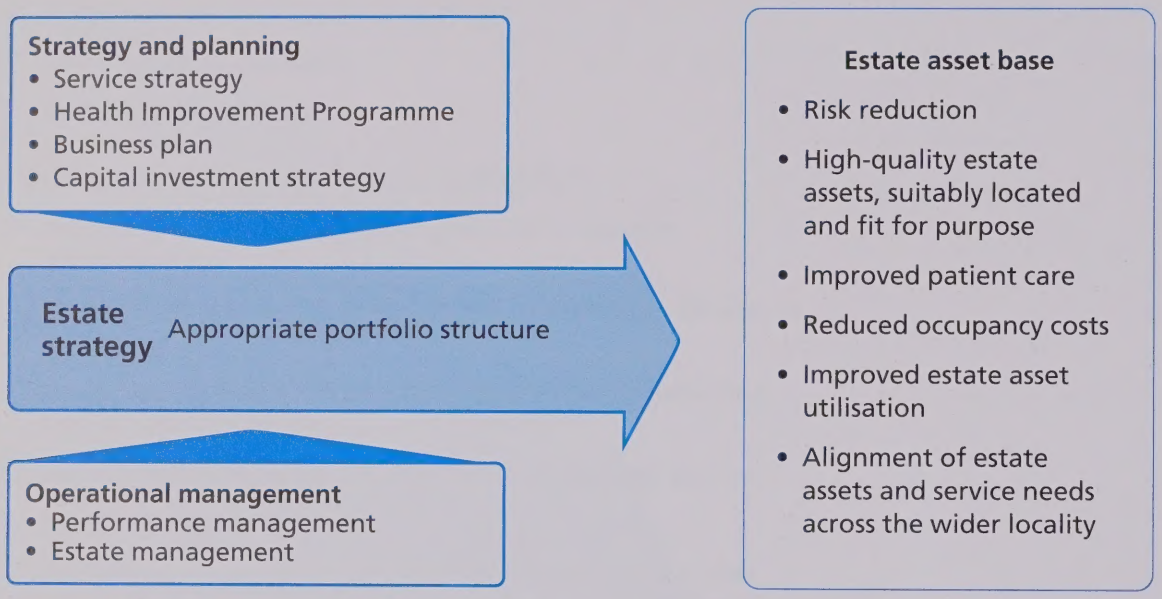
Section two:
What can be achieved through a best in class estate strategy

This section of the document summarises the expected outcome of implementing a best in class estate strategy.

What do we hope to achieve through our estate strategy?

The process of developing an estate strategy leads to a document that clearly sets out the way forward for the estate. An effective estate strategy will contribute to the implementation of high-quality health improvement programme and in turn to improving patient care in the context of modernising the NHS (see Figure 6).

Figure 6 Outcomes of an estate strategy


Strategy and planning
• Service strategy
• Health Improvement Programme
• Business plan
• Capital investment strategy
Estate strategy
Appropriate portfolio structure
Operational management
• Performance management
• Estate management
Estate asset base
• Risk reduction
• High-quality estate assets, suitably located and fit for purpose
• Improved patient care
• Reduced occupancy costs
• Improved estate asset utilisation
• Alignment of estate assets and service needs across the wider locality

The production of Outline Business Cases (OBCs) that cover the investment proposals will follow. There will also need to be an assessment of the suitability for each scheme for PPP. In the case of schemes over £25m, a strategic outline case will be produced, in conjunction with the health authority, for submission to the Regional Office. A well-thought-out estate strategy will be an essential precursor to the development of any business cases and the allocation of capital.

Estates strategies will be monitored on an annual basis by Regional Office estates and facilities teams. It is expected that they will form an integral part of plans for capital developments.

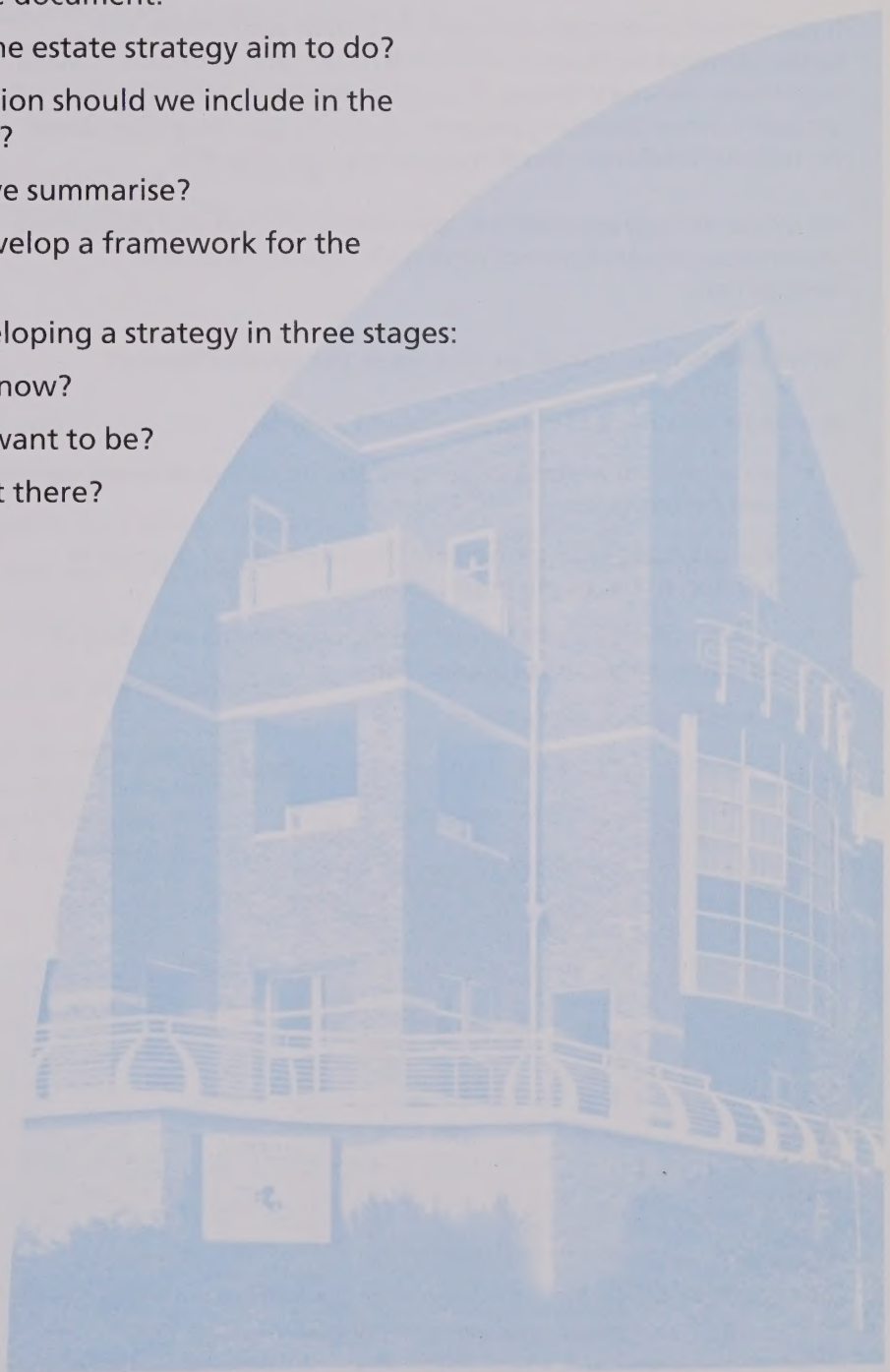
Completion of the process will also enable health authorities to clarify the links between the estate strategy of one trust and that of neighbouring trusts, since the majority of strategic service changes will have a knock-on effect on a number of organisations within the wider health economy.

The process of developing an estate strategy will therefore support and inform the overall direction of local health services and consequently should be an integral part of that development. It will be an essential element of any strategic direction and will be reflected in the HImP.

Section three:
How to develop your estate strategy

This section explains the stages of developing an estate strategy, looking at:

- the structure of the document:
  - What should the estate strategy aim to do?
  - What information should we include in the estate strategy?
  - What should we summarise?
  - How do we develop a framework for the document?
- the process of developing a strategy in three stages:
  - Where are we now?
  - Where do we want to be?
  - How do we get there?



The structure of the document

What should the estate strategy aim to do?

The estate strategy is a high-level document which should look forward at least five years, reflecting the NHS planning cycle. It is concerned with overall use of the estate and thus supply and demand costs, organisational constraints, and capital investment decisions.

It identifies how the present supply of capital assets meets the service demand for them in delivering healthcare. An estate strategy shows how the assets change through investment, acquisition or disposal to meet changing patterns of care. It also shows how value for money (VFM) is achieved in deploying capital assets.

An estate strategy provides the opportunity to meet and incorporate the expectations that patients and staff have of the clinical environment.

What information should we include in the estate strategy?

In a single document the strategy should include:

- an analysis of a trust's existing estate, including its condition and performance;
- the priorities for improvement, development or disposal in relation to the estate portfolio;
- a comprehensive estate investment programme including all capital expenditure proposals for:
  - meeting the service need;
  - meeting statutory and non-statutory standards;
  - reducing backlog maintenance;
  - procuring or renting new buildings;

Different approaches to estate strategies

It is possible to approach the development of an estate strategy in a number of ways:
1. Strategy can be viewed as a linear projection of the past: this assumes that change is logical and unidirectional, that the past is an accurate guide to the future.
2. Alternatively, strategy can be seen as a means of navigating a winding path, where organisations must twist and turn to overcome problems and external forces so that parts of the plan can be robust whilst others must be flexible.
3. A third view is that strategy is about evaluating and ultimately selecting from a range of possible options or scenarios: this approach aims to produce maximum flexibility for as long as possible.
Managers need to think about the most appropriate approach to their estate strategy because the consequences of their capital investment decisions are most likely to continue to impact on local healthcare services for decades.

Information

An environmental impact assessment contains:

- *a description of the likely significant effects of the estate, its buildings and operational activities, on the environment which result from the existence of the development;*
- *a description of the physical characteristics of the whole estate and land use requirements, including developmental and operational aspects;*
- *the use of natural resources;*
- *a description of the main characteristics of the products and processes, nature and quantity of materials used;*
- *an estimate, by type and quantity, of expected wastes and emissions – water, air and soil pollution – particularly addressing carbon gas emissions (caused by energy and transport provision etc) resulting from the operation of the estate and its services;*
- *an outline of the main alternatives and methods of avoiding, reducing and remedying significant adverse effects on the environment. This will include: an Environmental Strategy and a Healthy Transport Plan;*
- *a performance management methodology for environmental improvement and compliance with Government/DETR targets and requirements.*

The environmental effects of a development during its construction and commissioning phases, or with decommissioning or reinstating land, should be considered separately from the effects arising whilst it is operational.

  - upgrading and refurbishing of existing buildings;
  - operation of the estate;
- an environmental impact assessment which identifies the potential sources of harmful environmental effects;
- an action plan which aims to mitigate, reduce, remedy or avoid those negative environmental effects;
- development control plans for each major site;
- a summary of proposed acquisitions and disposals of land and buildings, and expected proceeds;
- an indication of how the above changes will deliver improvements in estate performance;
- a risk management strategy, which not only assesses compliance, but also sets risk-based priorities towards achieving full compliance.

What should be summarised?

The document should summarise:

- estate operational policies and procedures;
- annual planned maintenance programmes;
- labour management systems or best value strategies;
- estate management organisational structures;
- fire and safety planning procedures.

How do we develop a framework for the document?

Differing local circumstances will be reflected in an estate strategy, therefore no two documents will be exactly the same. The following framework is suggested for the document. It asks three basic questions:

Where are we now?

Where do we want to be?

How do we get there?

The detail of individual trust strategies can be adapted from it.

West Dorset General Hospital.
Architect: Percy Thomas Partnership
Photographer: Peter Cook

Where are we now?
You will need to collate:

- a current property schedule;
- a short history of the estate;
- current estate performance including functional suitability and site densities;
- a prioritised risk register;
- an environmental impact assessment;
- estate occupancy costs;
- current estate value, including the data your trust returns to ERIC;
- a summary of the priorities to be addressed;
- a current service profile;
- a District Valuer's report on the estate;
- a summary of meetings with clinical departments;
- patient perception surveys of your facilities.

Where do we want to be?
You will need to:

- obtain a summary of the strategic plan for providing local health services;
- assess the implications of the service strategy for the estate, that is, procurement, accessibility issues, design issues, functional suitability and space utilisation, disposals;
- assess the implications of local authority development plans;
- assess the opportunities for risk reduction in meeting needs of controls assurance;
- develop a trust policy for sustainable development of the environment together with an associated action plan and targets for improvement;
- collate planned and potential site and building disposals;
- set estate performance targets based on established PIs, benchmarks, and 'Estatecode' guidance on five facet surveys;
- ensure the supply of building space meets clinical need.

How do we get there?
You will need to:

- develop strategic options (where relevant) for estate change;
- plan a capital investment programme for major and minor schemes;
- plan a revenue investment programme;
- collate a summary of disposals and anticipated sale proceeds;

- compile site-based development control plans;
- forecast effect of strategy on estate performance;
- forecast effect of environmental strategy on improving environmental performance in partnership with the local authority;
- identify in outline the revenue impact of the capital investment programme.

The process of developing an estate strategy

This chapter describes in more detail the elements of the strategy framework outlined in the previous chapter. It describes the information that needs to be collected and suggests formats for its presentation.

Where are we now?

This initial stage is aimed at developing a comprehensive analysis of the current position and performance of a trust in relation to the services that it provides and the estate that it uses. The key objective of this stage is to establish a baseline that must reflect the overall service provision, and against which the development of options for change can be set.

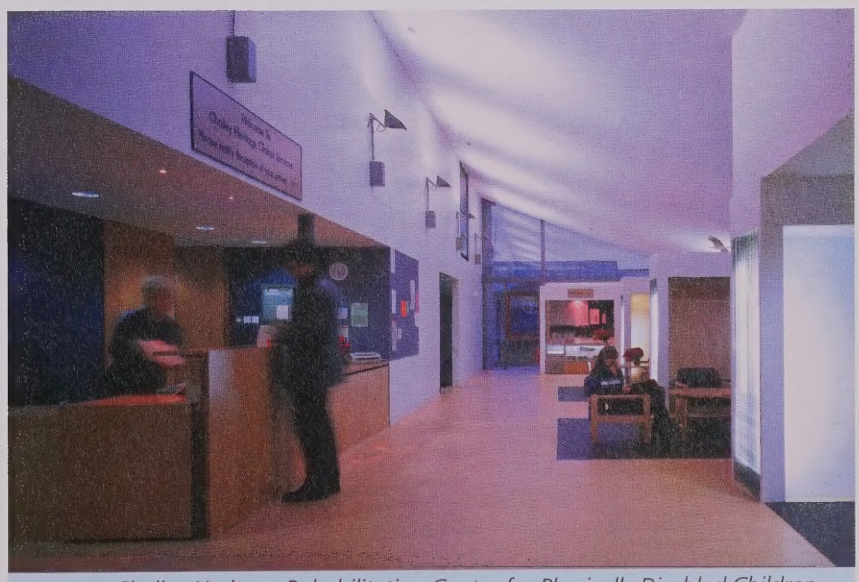
As part of the analysis, the trust will need to assess its assets, their utilisation and their relative performance. This assessment will be carried out in accordance with 'Estatecode' Volume 1, the features of which include the five facets set out on the following page. The assessment can be usefully supplemented by an aerial photograph if available.

Fact

One of the most important duties of estate professionals is to ensure that relevant information about the estate is made available in a timely manner to enable the estate strategy to be developed by the nominated in-house team.

Note

Estatecode is currently under revision.



Chailey Heritage Rehabilitation Centre for Physically Disabled Children
Architect: MacCormac Jamieson Prichard
Photograph: © Peter Durant/Arcblue.com

Estatecode categories are as follows:

Physical condition

A – the element is as new and can be expected to perform adequately to its full normal life;

B – the element is sound, operationally safe and exhibits only minor deterioration;

C – the element is operational but major repair or replacement will be needed soon, that is, within three years for building and one year for an engineering element;

D – the element runs a serious risk of imminent breakdown;

X – a rating added to C or D to indicate that it is impossible to improve without replacement.

Energy performance

A – 35–55 GJ/100 cu m

B – 55–65 GJ/100 cu m

C – 65–75 GJ/100 cu m

D – 75–100 GJ/100 cu m

Compliance with fire, statutory and non- statutory standards

A – a new building which complies with all statutory requirements and Firecode guidance;

B – existing buildings which comply with Firecode guidance and statutory requirements;

C – a building which falls short of A or B;

D – areas which are dangerously below either A or B.

Functional suitability

A – high degree of satisfaction;

B – acceptable/reasonable: no major change necessary;

C – below an acceptable standard;

D – unacceptable in its present condition;

X – supplementary rating added to D to indicate that the facility is so below standard (or so impossible to improve) that nothing but a total rebuild will suffice.

Space utilisation

1 – Empty

2 – Under-used

3 – Adequate

4 – Overcrowded

Analysis of the existing estate

Physical condition

The physical condition profile examines the building structure and fabric together with mechanical and electrical engineering installations.

It shows what proportion of the building area is in one of five condition categories, and the backlog cost to upgrade these areas to acceptable standards (that is, at least Estatecode condition B).

Energy performance

The energy condition profile examines the building structure and fabric together with mechanical and electrical engineering service installations for energy efficiency. The NHS target for the healthcare estate is 35–55 GJ/100 cu m. Energy is difficult to measure across a large site, as most buildings are not individually metered; therefore an energy audit will need to be carried out to assess problems with individual buildings.

Compliance with fire, statutory and non-statutory standards

There is a wide range of statutory standards relating to hospitals and a number of non-statutory standards required by the Department of Health, with which compliance is required through controls assurance and will result in a risk register. These include some Health Technical Memoranda and Health Building Notes and all Firecode documents. Analysis provided half-yearly to Heads of Estates and Facilities identifies the proportion of the building stock that complies with these standards, and costs required to ensure full compliance.

Functional suitability

The functional suitability analysis describes how effectively a site, building or part of a building supports the delivery of a specified service. The criteria used in such assessments include:

- space relationships;
- services;
- amenity;
- location;
- environmental conditions;
- overall effectiveness.

Space utilisation

The space utilisation analysis indicates under- or over-utilised floorspace. Under-use of space is serious since it represents a waste in terms of property overhead costs, for example energy, maintenance, cleaning, capital charges, rates. Unused spaces may be difficult to reuse or release because of their physical features, scattered locations, and physical barriers to their rationalisation. Over-utilised space may impede the effective delivery of healthcare.

An analysis of the existing estate should be presented in a table as illustrated in Table 3.1 (see Appendix 3). The resulting information can be graphically represented in a series of pie charts (Figure 7) and histograms (Figure 8) to demonstrate the percentage of the estate in each assessment category and the backlog cost to bring the estate to an acceptable standard.

Notes

For tables see Appendix 3

The analysis will incorporate a summary of backlog maintenance. This summary should set out the current area of the estate which is in an unacceptable condition (Estatecode conditions C and D) and the expenditure needed to ensure that planned maintenance adequately preserves the buildings in adequate condition at all times. Planned preventative maintenance expenditure on major items of plant and building fabric should be included. These data can be summarised graphically as in Figure 9.

A major driver will be the controls assurance process, which is primarily a self-assessment using internal methods of control (see page 5).

Further analysis of the building floor area (sq m) occupied within the overall trust estate should be carried out; that is, the ratio of the building floor area to site area (sq m/hectare). Using the Estates Returns Information Collection tool (ERIC) to compare this data against that of similar trusts will help to show how efficiently the estate is being used and to identify those parts that may be disposed of (see Appendix 1).

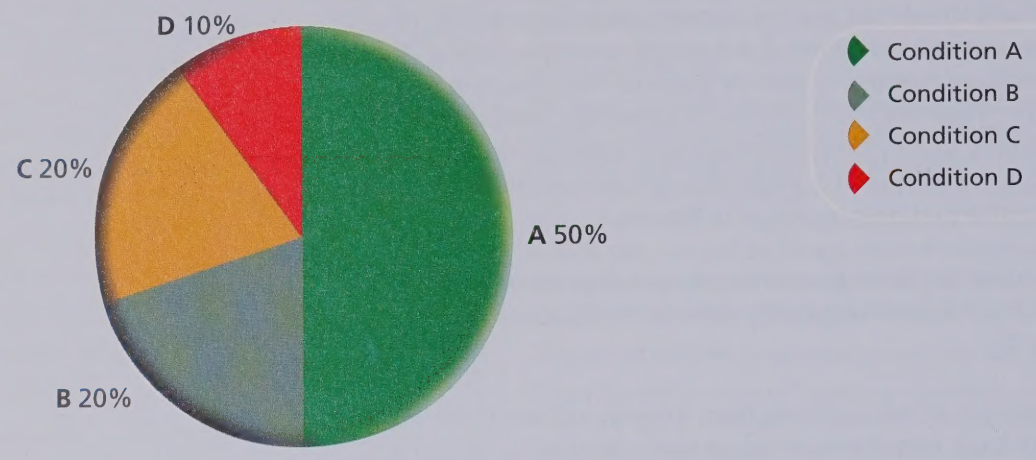
On average, approximately 20% of annual income will be expended by trusts on the operation of fixed assets. Occupancy costs should be determined for a trust's estate to provide a baseline measure against which to seek improvements. The cost of the fixed asset overheads should be brought together in a standard format as shown in Table 3.2 (see Appendix 3).

Derbyshire Children's Hospital
Architect: Trent Architectural Design
Photographer: Graham Gaunt Photowork

Figures 7 and **8** The physical condition of the estate

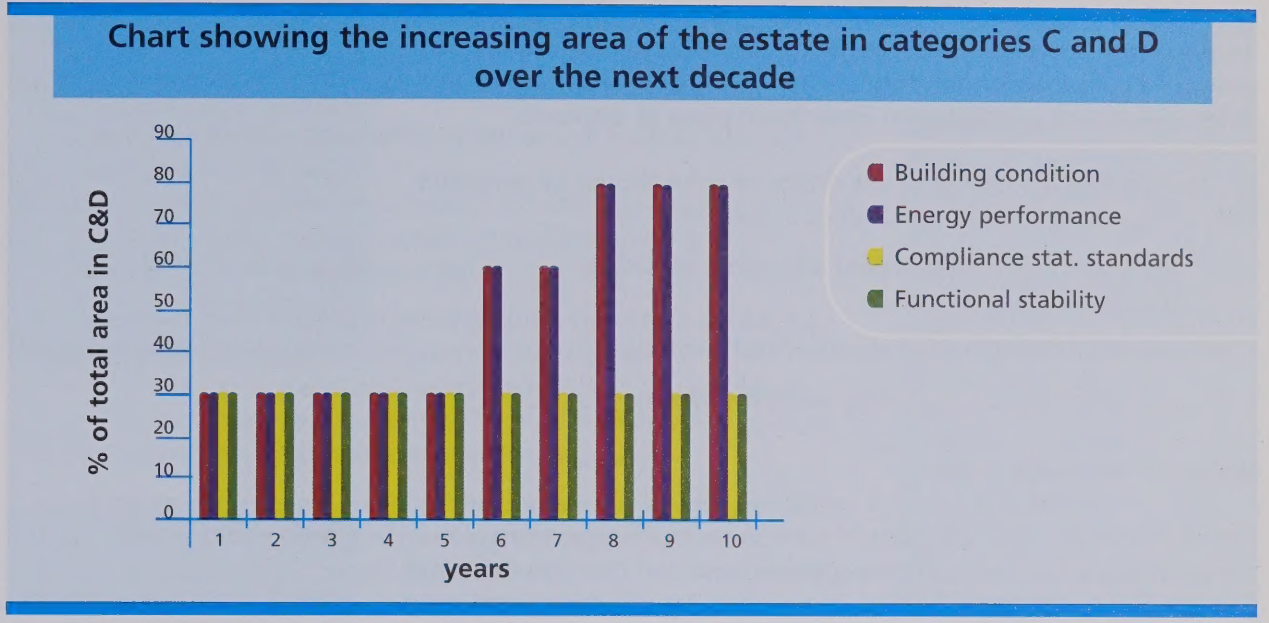
The physical condition of the estate and the cost to upgrade to an acceptable condition (Estatecode condition B) are shown below

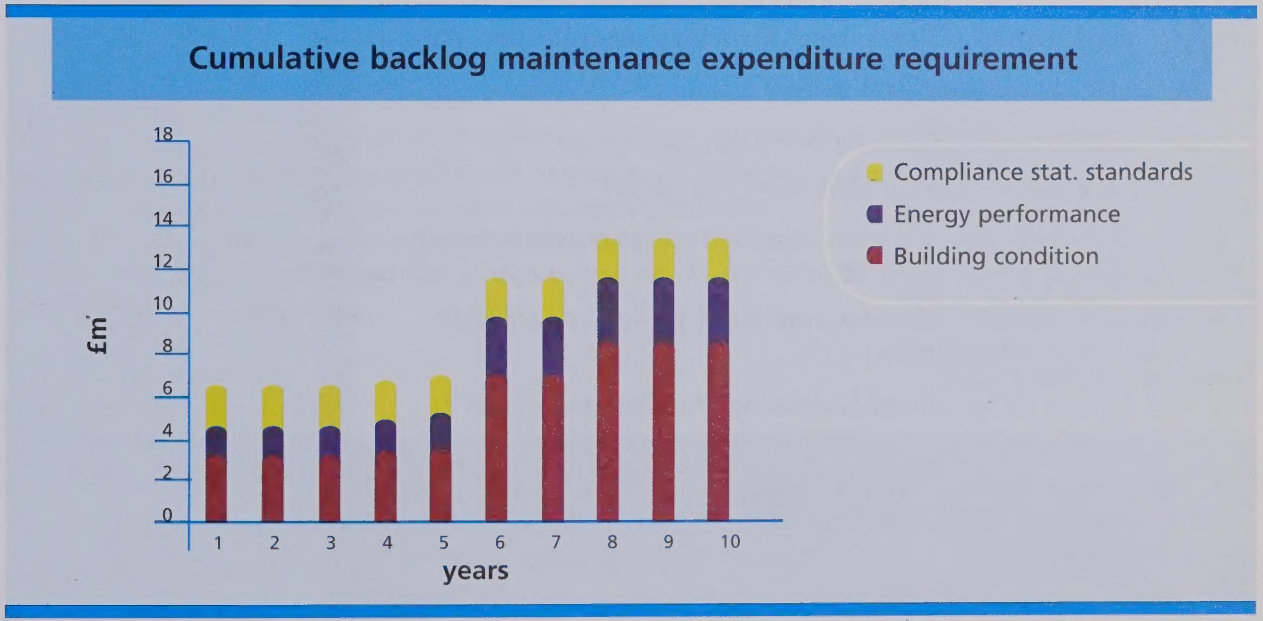
Condition of the estate (% by the floor area)



Cost to upgrade to an acceptable condition (Estate condition B)

Figure 9 Backlog maintenance summary





The 'Where are we now?' section of the strategy document should also make reference to plans in relation to historic buildings, where appropriate. Detailed guidance on historic buildings is contained in NHS Estates' publication 'Historic Buildings and the NHS'. Where a trust's estate includes historic buildings, the trust will be required to prepare a conservation brief for each building and to adhere to NHS Estates guidance in relation to investment plans or disposals.

A summary of the findings of the estate analysis should be prepared. This should draw specific conclusions in terms of:

- black spots that need urgent attention, including environmental problems;
- opportunities for rationalisation and disposal;
- opportunities for improving value for money.

Where do we want to be?

This section of the strategy should summarise the longer-term plans for health services that have already been reached through the HImP process. Whilst these may not be comprehensive, or several options for change may be under consideration, this should not prevent the development of an estate strategy by the trust, provided that proposals for investment or divestment are clearly contingent upon the ultimately agreed service strategy.

The implications for the estate of the service strategies should be outlined in this section. For example:

- are new site acquisitions required?;
- what type and size of site is required?;
- what are the anticipated town planning issues?;
- can changes in service involve whole-site disposals (in order to maximise revenue savings)?;
- can some sites be more intensively used, through new builds, adaptations, link corridors etc?;
- can services be co-located on existing sites (for example on community hospital sites or primary care premises)?;
- what requirements exist for the provision of staff residential accommodation, and how and where should that be provided and managed?;
- will possible transfers of services out of an acute hospital setting require more highly engineered local sites, including IT links?

The estate strategy should demonstrate how the estate is supporting clinical services.

Historic buildings

'Historic buildings and the NHS' contains useful guidance including maintenance, alterations, managing surplus buildings, disposal and acquisitions involving historic buildings. For further information contact NHS Estates Policy and Performance Management – telephone: 0113 254 7149

The patient journey

Most of the section "Where are we now?" addresses the measurable estates facets from a professional perspective. It may be appropriate in some patient areas to measure patients' perceptions of the facilities provided.

NHS Estates has developed a quality assurance model for the patient journey which helps to assess the quality of the patient environment. It can be used as a tool for the planning, targeting and confirmation of improvements achieved.

For further information see Appendix 2 and the Policy and Performance Management section on the NHS Estates website – www.nhsestates.gov.uk or telephone: 0113 254 7000

Establishing estate performance targets

An essential component of this section of the strategy will be the establishment of estate performance targets, against which the performance of the estate can be monitored and measured.

Appropriate performance targets should be set that will measure:

- improvements in the quality of the operational estate over time;
  (these can be measured through reductions in backlog maintenance, through annual perception surveys and environment measurement tools)
- improvements in statutory compliance, reduction in risk, and achievement of controls assurance standards;
  (these can be measured through reduction in non-compliance, reduction in incident rates and improvement in self-assessment scores, see 'Reporting requirements', page 33)
- changes in the revenue cost of the operational estate over time;
  (these can be measured by mapping trends in overall maintenance costs, utilities costs and a trust's income-to-asset value ratio, against a common base point)
- improvements in the utilisation of the estate over time; that is, seeking out underused and surplus assets;
  (these can be measured through site density, asset value and income ratios)
- improvement in the quality of the environment for patients.
  (this can be achieved using the patient journey model; see Appendix 2)

NHS Estates has developed a series of performance indicators for the estate, from which a trust can benchmark its estate performance and monitor improvements. The performance indicators have been refined into five groups: space efficiency, asset productivity, asset deployment, estate quality and cost of occupancy, which are defined in Appendix 1.

Information

A performance indicator is available to assist in the identification of surplus estate, and this relates to site density. The ratio concerns how building area compares against site area. For example, trusts with a low-density ratio may own more land than is actually required to deliver patient services. The ratio will be influenced by location, number of properties within the trust, and the nature of services delivered. This is particularly relevant for community rather than acute trusts, due to the nature of service provision.
Trusts need to rigorously analyse each of their sites for comparison with the average for their cluster. The aim is to drive out surplus property, ensuring an efficient and effective estate for the delivery of local healthcare.
Regular monitoring of these ratios will show how effective the trust policy is at modernising and rationalising the estate through better use of its land and buildings.

Chailey Heritage Rehabilitation Centre for Physically Disabled Children.
Architect: MacCormac Jamieson Prichard
Photograph: © Peter Durant/Arcblue.com

Each of these groups contains in its turn four different performance indicators. Benchmarking these indicators against regional and national averages will illustrate the potential for the trust to improve the management of its assets. In addition, the same indicators could be used to identify potential targets for investment and to support business cases to secure capital funding.

As part of the feedback to NHS trusts, a central returns data analysis document is released periodically as a supplement to 'Quarterly Briefing' (now on the NHS Estates website). This illustrates trends across a range of estate performance indicators and allows trusts to make trend comparisons against other trusts or hospitals of a similar age, type and size. These trends are developed from information supplied by trusts in their mandatory returns of estate performance.

Information

The central returns data analysis document is sent to trusts by NHS Estates. For further information see NHS Estates' website at www.nhsestates.gov.uk or telephone 0113 254 7000.

How do we get there?

The final section of the estate strategy document will use the information and outputs of the preceding stages to develop realistic and feasible options for the future estate. It should describe in a concise way the practical steps to be taken by a trust to achieve the objectives set out in the previous stage of the process.

This is the difficult part of the estate strategy development process, where it is absolutely essential to involve several "creative and design-based" thinkers who can:

a. envisage the "big picture";

b. provide illustrations of changes to it very rapidly.

Montpelier Health Centre
Architect: Vic Love Architects. Photographer: Mark Bolton

At this stage it is worth repeating that it is essential in drawing together the elements of the strategy to ensure the involvement of financial, general and business managers from throughout the trust, clinicians whose services are affected, and staff from the health authority and primary care groups. This approach should help to generate a broader understanding of the importance of the estate in strategic planning.

The preparation of a capital investment programme

A capital investment programme should be prepared and incorporated into this section of the strategy document (see Table 3.3 Appendix 3). This should show the total capital cost and timing of the schemes required to implement the estate strategy. All costs should be shown in £ thousands and should include equipment, fees (according to the cost headings in the OB1 form) and VAT, irrespective of the financing mechanism chosen for the investment.

Information

The Outline Business Case Form (OB1) is in the CIM 'Business Case Guide'.

The timing of known or anticipated land and property disposals or acquisitions which will result from the strategy should be set out in the format illustrated in Table 3.4 (Appendix 3). Depending on the approach agreed locally towards the use of capital receipts, it may be useful to indicate forecast disposal receipts netted off against cumulative capital expenditure.

Note

Surplus estate may arise in the following situations:

- *service reconfiguration;*
- *rationalisation of services;*
- *NHS trust mergers;*
- *proposals for future capital investment;*
- *transfer of property to Primary Care Trusts.*

Programmes over the period of the document for major planned maintenance and for the reduction of backlog maintenance should provide further details on the areas covered and the priority order, for example compliance with statutory and non-statutory standards such as Firecode, COSHH, Electricity at Work Regulations, the Health and Safety at Work etc Act and the Disability Discrimination Act.

Each estate strategy or new capital investment project should include an environmental impact assessment. This should cover the three criteria of economic, social and environmental impacts that will occur as a result of the development being provided. It is not just about construction materials and processes, it involves decisions on such issues as:

- what impact will the option/proposal(s) have on the local community?;
- does (or could) public transport provide access to the site?;
- are there local services to support the proposed development (for example waste collection, disposal services etc)?

Development control plans should be prepared to indicate in diagrammatic form the major changes that are planned by the trust.

Measuring the effect of a strategy on estate performance

Targeted improvements in the chosen estate performance indicators, which will result from the implementation of the estate strategy, should be clearly set out. Progress against these indicators will be regularly monitored. Examples include:

Chiddenbrook Surgery, Devon.
Architect: Smith Roberts Associates.
Photographer: Christopher Bland

- reduction in total building area linked to new capital investment in order to keep income-to-asset ratio stable;
- improvement in space utilisation resulting from the above;
- improvement in energy performance in order to deliver a reduction in expenditure on engineering maintenance and overall reduction in greenhouse gases;
- improvement in site utilisation and addressing transport needs of staff, contractors, patients and visitors;
- improvement in patient perception measured through the use of the patient journey model (see Appendix 2);
- improvement in site density ratio to ensure that the optimum-sized estate is being achieved.

Risk management and controls assurance

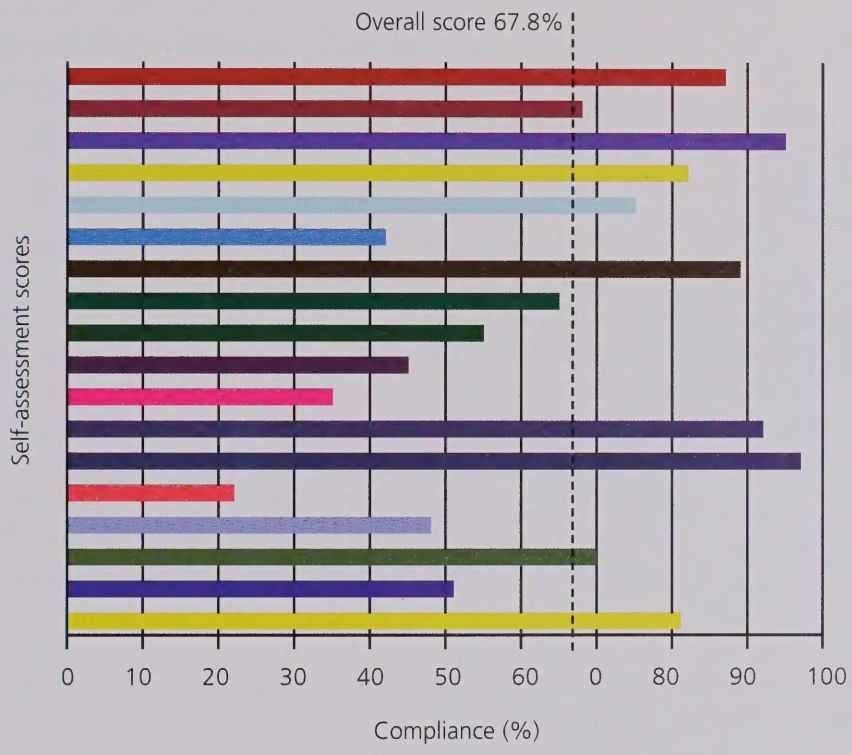
Controls assurance is, primarily, self-assessment using internal methods of control. Internal audit is the main agent of validation and monitoring within each organisation. It quantifies the significant risks that a trust faces across the whole range of its operations. These will be incorporated into the estate strategy along with the investment plans, supported by achievement in risk reduction against investment.

Reporting requirements

NHS trusts and health authorities should communicate annually the results of their organisation-wide baseline assessment against relevant standards to their NHS Executive Regional Office.

Tabulated scores will be used to generate a graphical 'baseline profile' for each NHS organisation, including an 'overall score' (see Figure 10 below). Regional Offices will monitor implementation of action plans with reference to ongoing improvement against the baseline profile.

Figure 10 Exemplar organisation-wide baseline assessment



- Risk management system
- Buildings, land, plant and equipment
- Catering and food hygiene
- Contracts and contractor control
- Emergency prepardness
- Environmental management
- Fire safety
- Health and safety management
- Human resources
- Infection control
- Information management and technology
- Medical devices management
- Medicines management
- Professional and product liablity
- Records management
- Security
- Transport
- Waste management

Boards should ensure that there is a structure in place for the controls assurance system which assesses achievement and sets risk-based priorities for maximum achievement. The key is:

- reduction in risk through improvement in compliance, indicated by improved controls assurance self-assessment scores.

The estate function should also be concerned with financial risk:

- the management and reliability of the cost and timely provision of items other than space, such as services or products required in the operation of corporate facilities.

Conclusion

A meaningful estate strategy has to be based on good quality information about the condition and performance of the existing estate. This must be used as the basis for future improvements; and those improvements must be measurable.

The strategy must also seek to reduce risk, not only through improved compliance, but through a reduction in incidents and improved perception by users. It is important to understand the revenue costs associated with the estate and how they compare with the best in class. Strategies should recognise the need to demonstrate best value.

It is critical to ensure that space is fully used, both in density of occupation and frequency of use; driving out facilities that are duplicated, over-provided or no longer necessary in the delivery of effective healthcare.

Recurring savings drawn from the asset base can either be invested in new capital assets or diverted to enhance patient care.

The Boothroyd Centre at Dewsbury and District Hospital
Architect: Fletcher Joseph
Photographer: Vince Chapman Studios, Dewsbury

Appendix 1: Estate strategy performance indicators

NHS Estates has developed a suite of estate strategy performance indicators (PIs) which are designed to allow informed judgement on the efficiency and condition of the estate. All are based on indicators that are expressed as a ratio of a trust's building and land areas.

A simple traffic light exercise classifies performance management information into three categories:

- green – no or very limited problems;
- amber – some problems;
- red – serious concerns (see table of trust performance overleaf).

The use of radar capacity charts using the performance indicators demonstrates the potential for a trust to improve its asset management against similar organisations and the national average for its cluster. They also assist trusts, health authorities and Regional Offices to compare high-level performance and will provide a basis for identifying potential areas for improvement as well as role models. For example, consistently poor performance targets may indicate that there is surplus estate within the trust, which should be identified and made available for disposal.

Each trust is grouped with others using the NHS Executive's top-level clustering, that is, acute, teaching, multi-service, priority and ambulance, so that comparisons are of like organisations.

The performance indicators and groupings within the radar capacity charges are designed to cross check and verify in a meaningful way the condition of the estate in supporting the delivery of patient services.

The performance indicators illustrated are based upon an anonymous trust and are for information purposes; the commentary that accompanies each radar chart is therefore indicative only. NHS Estates will provide the charts on an annual basis; however, it will be necessary for trusts to prepare their own commentary and analysis. NHS Estates Regional Offices will be able to help.

Table of trust performance

PI	Trust PI score		Cluster PI bands		
			Below	On or between	Above
1					
Income £10/m²	119		89	89 and 107	107
Activity/100 m²	99		61	61 and 74	74
Asset value £10/m²	105		77	77 and 91	91
2					
Capital charges £/m²	39		82	82 and 95	95
Land £/m²	100		70	70 and 122	122
Building £10/m²	85		60	60 and 72	72
Equipment £/m²	99		61	61 and 88	88
3					
Occupancy cost £/m²	70		115	115 and 131	131
Capital charges £/m²	39		82	82 and 95	95
Maintenance costs £/m²	14		14	14 and 16	16
Energy/utility costs £/m²	6		7	7 and 9	9
Rent and rates £/10 m²	73		86	86 and 115	115
4					
Total backlog £/m²	200		47	47 and 129	129
Physical backlog £/m²	100		31	31 and 99	99
Health & safety + Fire backlog £/10 m²	140		75	75 and 227	227
Depreciation £/m²	11		36	36 and 43	43

Note: m² = floor area

Summary

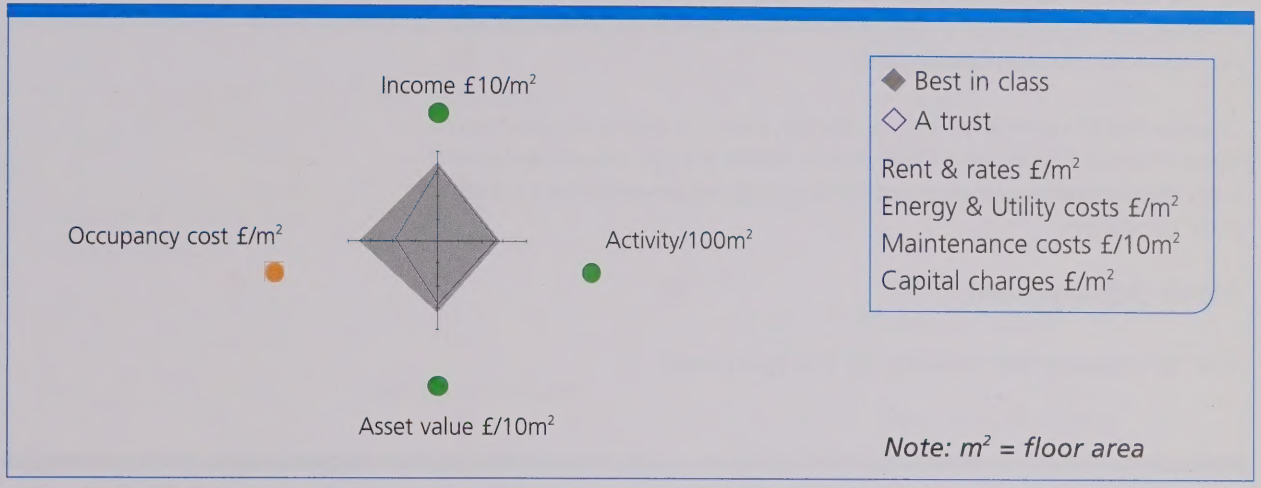
The trust is generally using floor space efficiently, because its income, activity levels and asset values are all good.

However, the Performance Indicators suggest an asset base that may be near the end of its designed life and possibly in need of investment and rationalisation to achieve a more modern and functionally suitable estate. There are also strong indications that the quality of this estate is generally below acceptable standards.

It is not always possible to deduce strong messages from these performance indicators, and therefore it will be necessary to seek assistance from your regional estates team and use local knowledge and interpretation to fully understand the data.

Space efficiency

Aim: to relate the estate and its annual occupancy cost to the output of the trust

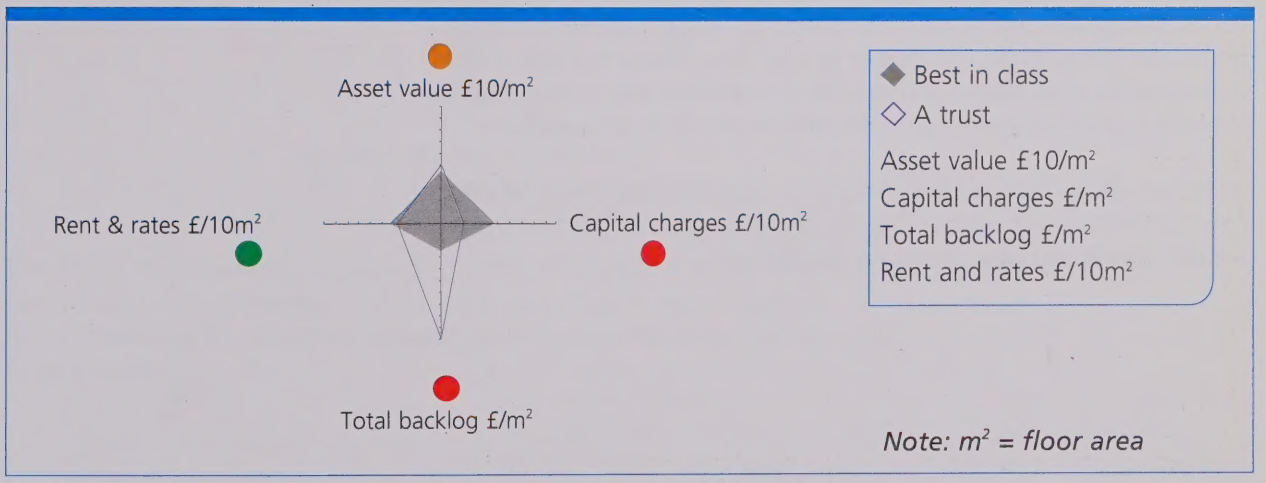


This PI indicates that the trust is generally using floor space efficiently, because its income, activity levels and asset values are all good, relative to the gross internal floor area, when compared with similar NHS trusts.

There is however a concern that the trust is not investing sufficiently in occupancy costs, which, if not reviewed, may lead to increasing financial pressures in future years (for example from backlog maintenance expenditure requirements or lack of capital for reinvestment from capital charges).

Asset productivity

Aim: to demonstrate the actual cost of owning/renting assets



This PI suggests that the trust needs to improve its performance with respect to capital charges and backlog. The trust should aim to increase spending on capital by heavy investment and rationalising its estate to achieve a more modern and functionally suitable estate.

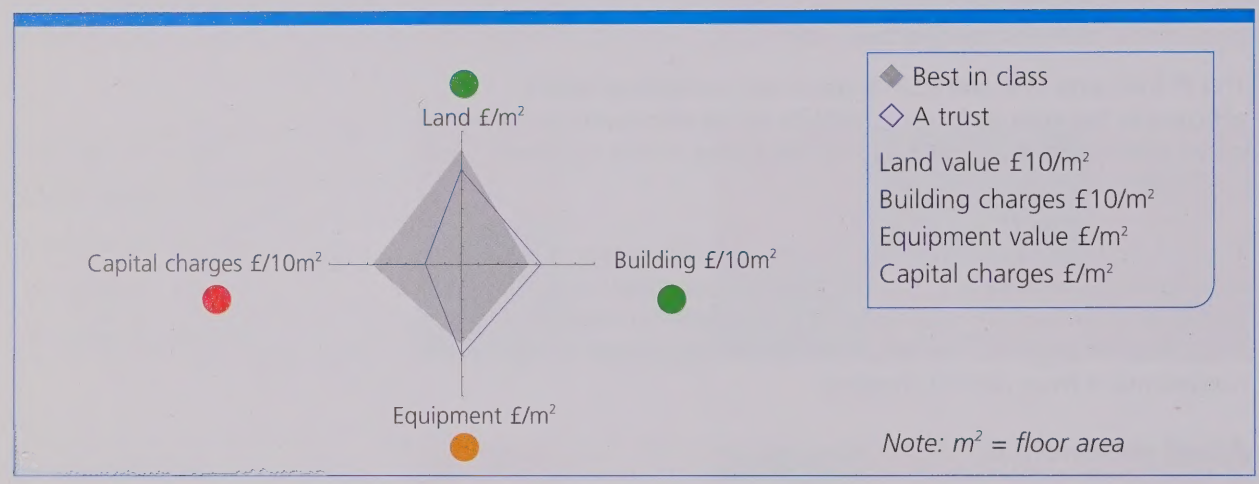
Similarly, its backlog PI, which is relatively high, suggests an estate which may be near the end of its designed life, with an increasing number of backlog failure and replacement pressures.

Whilst the rent and rates figures are relatively low, this could also be a reflection of an older estate, which may be less appropriate for the provision of modern healthcare.

Despite the PI comments noted above, there is also a suggestion in these PIs that the value of the trust's assets is high when compared with the rest of the cluster group, suggesting an oversized estate in poor condition.

Asset deployment

Aim: to compare the makeup of the asset base

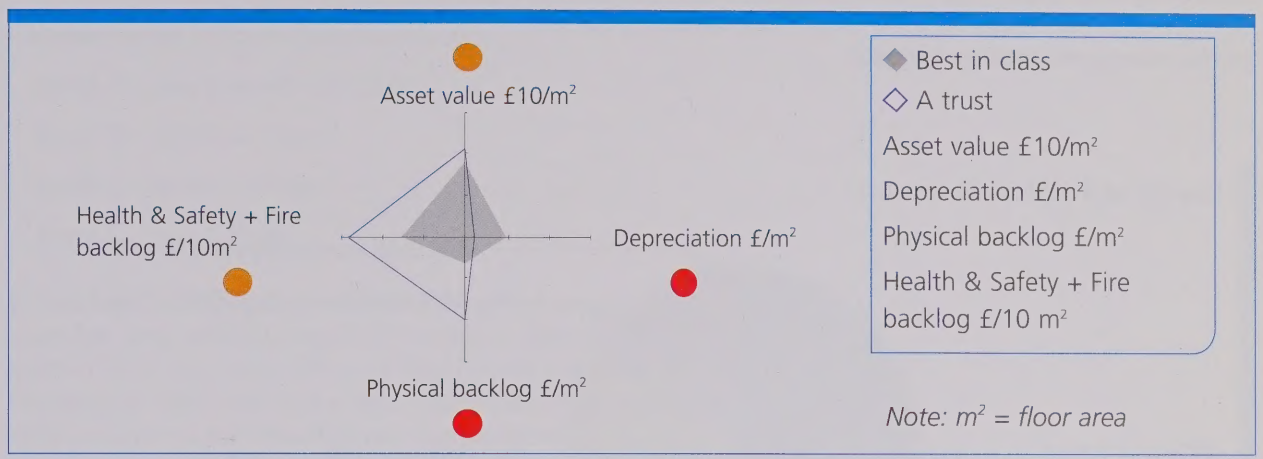


These PIs suggest that the trust utilises a "normal" quantity of land for its needs, but the value of its buildings and equipment are generally higher than the cluster group. The reason for this is not immediately clear and requires local knowledge and interpretation. However, the PIs suggest an oversized estate in poor condition.

As noted above, the capital charges PI suggests that the trust needs to improve its performance. Again, this PI suggests that the trust should aim to increase spending on capital.

Estate quality

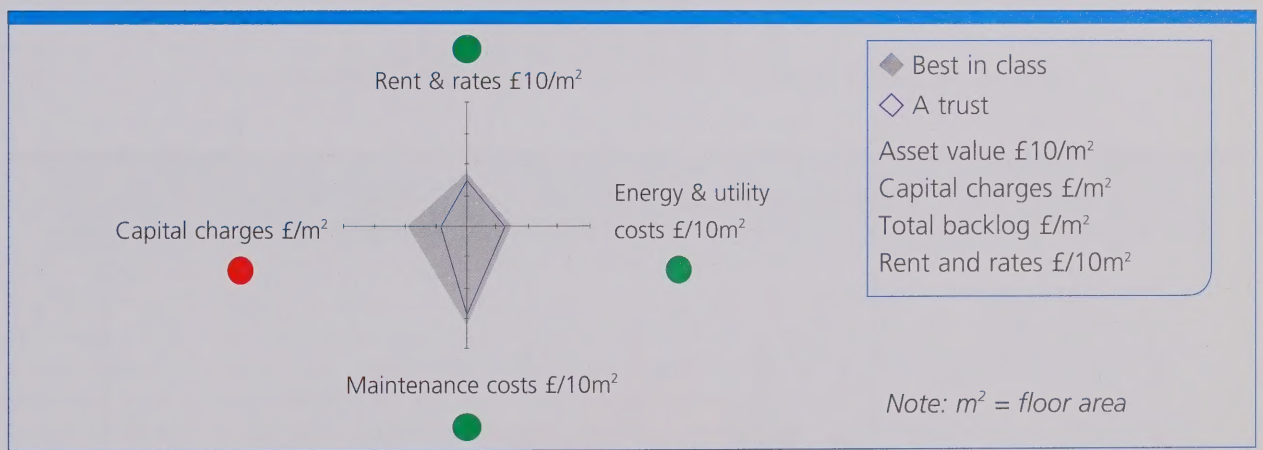
Aim: to give a balanced view of the overall condition of the estate relative to value and age



All four of the Estate Quality PIs fall short of comparable standards in the cluster group, suggesting that the quality of this estate is below acceptable standards. There should be particular concern about the trust's depreciation and physical backlog situation.

Cost of occupancy

Aim: to identify the profile of occupancy costs (revenue).

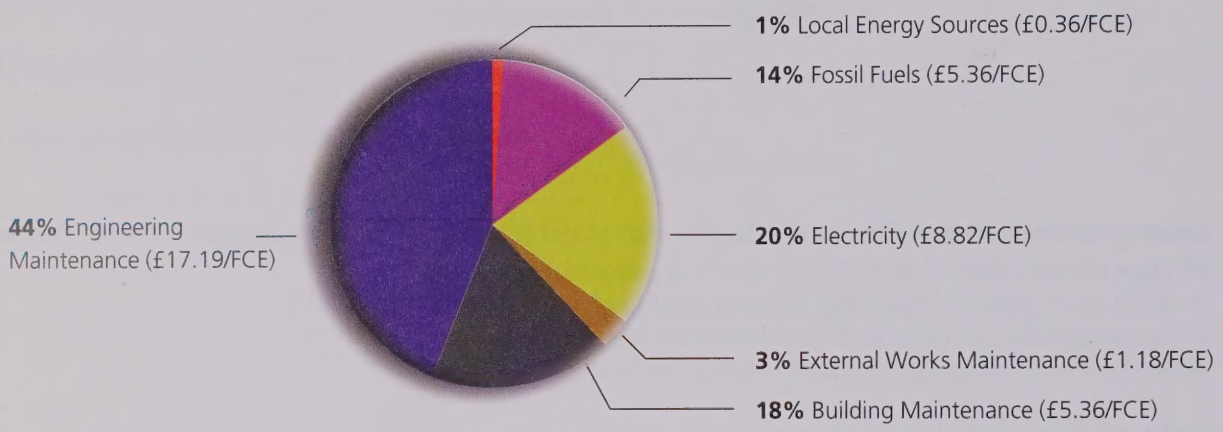


The PIs for maintenance, energy and utilities suggest that the trust is performing well. However, if the trust's spending on maintenance drops at all, the backlog maintenance will be unacceptably high in future years.

Second level performance indicators

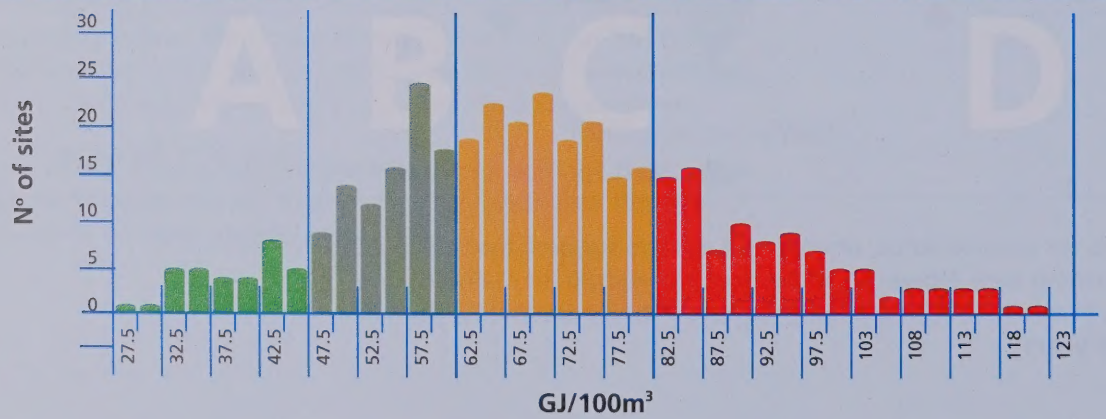
Trusts should also include second level indicators in their estate strategy. These will normally be presented in graphical form as in the following examples. They may be supported by spreadsheets giving greater detail and may be used to usefully compare current performance with future targets.

Energy and maintenance costs


1% Local Energy Sources (£0.36/FCE)
14% Fossil Fuels (£5.36/FCE)
20% Electricity (£8.82/FCE)
3% External Works Maintenance (£1.18/FCE)
18% Building Maintenance (£5.36/FCE)
44% Engineering Maintenance (£17.19/FCE)

The pie chart assists trusts in identifying a cost per FCE.

Un-normalised energy consumption



Assessment on energy consumption should be based on the energy used per unit volume (GJ/100m^3). The size of the trust, the ages of the buildings, the type of trust (eg acute, community, etc) can all affect consumption per m^3. The NHS target for healthcare estates is 45-60 GJ/100m^3 or better.

Categories for efficiency are as follows:

Band A – less than 45 GJ/100m^3

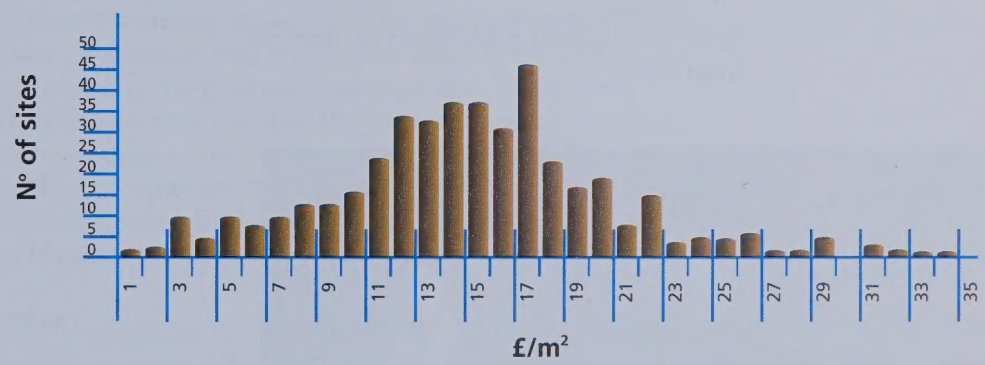
Band B – 45-60 GJ/100m^3

Band C – 60-80 GJ/100m^3

Band D – 80+ GJ/100

Broad band rankings are required to reflect building type, what it is used for, and who is using it. It is evident that those buildings or parts of buildings with 24-hour occupation will consume energy on a continuous basis, while the intermittent energy use of premises used only in daytime will result in less consumption.

Building and engineering maintenance costs



This chart shows the range of expenditure in £/m^2 in Building & Engineering maintenance cost in the NHS. It indicates a clear peak between 11-19 £/m^2. However it is not possible to indicate a target which trusts should aim for on this diagram because every trust is different and an expenditure of, for example, £11/m^2 in trust A may be too little for trust B. Variables that could affect this are cost of backlog, size and age of the estate and degree of advancement of rationalisation of estate.

Definition of terms

Income	Total income for the trust
Activity	Finished Consultant Episodes (FCEs)
Capital charges	Capital charges for the trust
Rent and rates	Rent and rates for the trust
Maintenance costs	Engineering, building and ground works costs
Energy and utility costs	Energy and utility costs (including water)
Occupancy costs	Capital charges + Rent and rates + Maintenance costs and Energy and utility costs
Physical backlog	Cost to bring physical condition up to an acceptable standard
Health & Safety + Fire backlog	Cost to bring H&S and fire condition up to an acceptable standard
Total backlog	Physical backlog + H&S backlog + Fire backlog
Land value	Land asset value
Building value	Building asset value
Equipment value	Equipment asset value
Asset value	Total land, building and fixed equipment asset value

Bedfordshire and Shires Health & Care NHS Trust (now Bedfordshire and Luton Community NHS Trust) – Highly Commended in the 1998 Healthcare Estate Management Awards for the Best Estate Strategy

Appendix 2:

The NHS Estates Quality Assurance Model (The Patient Journey) Toolkit for patient facilities

This toolkit was devised originally for Accident and Emergency (A&E) Departments. However, it can be adapted for use in other patient areas.

For further information and a copy of the toolkit in electonic format, contact NHS Estates Policy and Performance Management – telephone 0113 254 7000.

Purpose

The toolkit has been devised to enable managers to determine what needs to be done to improve the quality of the patient environment. The results from the survey analysis can be interpreted to identify strengths and weaknesses and enable resources to be targeted at those areas requiring the greatest improvement. The surveys therefore need to be structured so that they may be conducted firstly before any upgrading works, which may be planned and then again after their completion. The reference to returns being made to Regional Offices is solely in the context of the Accident and Emergency Modernisation Fund.

Introduction

- What is the purpose of this toolkit?

This toolkit is intended as a method of assessing the quality of the patient environment associated with an A&E department, to assist trusts in identifying which areas require improvement. The results of the surveys may be used to support bids for funding from the modernisation fund and for assessing the effectiveness of the finished schemes. The toolkit is not designed to compare the results across trusts (as may be done in a benchmarking methodology). The results are intended for the trust's own use in order for them to understand their own particular situation and to demonstrate their situation to their Regional Office.

- When should the toolkit be used?

The toolkit is designed to be used in two stages. Firstly, before a scheme for upgrading a department has been devised, it can be used to inform the briefing processes. Secondly, after that same scheme has been completed, it can be used to obtain feedback which is directly comparable with the first survey. The toolkit is also useful for setting targets which can be viewed alongside the before and after survey results.

The survey therefore can be utilised to demonstrate the benefits of a capital scheme or investment by comparing people's perceptions of the environment before, and the benefits gained after investment.

- Why do I need to do these surveys?

The surveys give a high level indication of people's satisfaction in thirteen main categories. The survey data will enable you to establish where the facilities and the environment are below a satisfactory standard. Further consideration and interpretation of the data will allow you to identify specific areas for improvement. In some instances it may be necessary to carry out more detailed surveys to ascertain precisely what action needs to be taken.

- How is the toolkit to be used?

The toolkit is designed for use by patients, users of the department and staff. It can be applied to all sizes of facilities and can also be modified for other departments. It contains ready-made survey sheets and an Excel spreadsheet package, which will convert survey data into graphs that numerically identify people's perceptions of the A&E environment. It also contains some advice and guidance on interpreting the results of the survey. The results are indicative rather than prescriptive and it may be necessary to carry out further work to support any bid for funding against the modernisation fund. It is intended that the surveys should be carried out on samples of patients, visitors and staff within the department.

- Who will use the toolkit?
  - Trust chief executives and hospital managers who wish to bid against the modernisation fund;
  - Estates and facilities managers who wish to understand people's perceptions of their A&E environment; identify areas for improvement; and to demonstrate improvements;
  - The Regional Offices and the Secretary of State in order to understand the benefits that have accrued to trusts, and to the wider NHS.

Staff with responsibility for investment and decision-making within the organisation should interpret the results of the survey.

The physical environment

The physical appearance and layout of a hospital, in particular an A&E department, is important since it will influence the behaviour of all those who use its facilities: patients, staff and visitors.

Hospital buildings should provide a safe, stable and predictable environment enabling better care and treatment of patients. From entering the hospital site the location of the department and routes through to waiting and treatment in other areas should be clearly signed, legible and accurate.

Careful use of colour and good lighting will reduce feelings of tension and anxiety. Seating arrangements, signposting,

temperature and noise levels can all affect not only the ability to perform physical tasks and functions, but also reduce stress levels of both staff and patients.

The components of the survey system and toolkit:

A An A&E Department (or other patient area) requiring upgrading

B A site or trust research manager with clerical support

C A team of researchers

D People (patients, staff and visitors) to be questioned

E The tool kit, comprising:

- instructions
- questionnaire prompt sheets with 13 questions (also on a Word file on the disc)
- questionnaire cover sheets (to be completed one per interview) (also on a Word file on the disc)
- questionnaire score sheets (to be completed one per interview) (also on an Excel file on the disc)
- an Excel computer software package comprising: two survey data entry worksheets (before and after) with complementary quality profile charts, one target data entry worksheet with complementary quality profile chart, a combined quality profile chart showing all three profiles, and a Regional Office data return worksheet.

Instructions for use

It is intended that the surveys be conducted with assistance from researchers. These may be staff from any of several disciplines such as estates, nursing, administration etc, as agreed at the start of the project. It is suggested that a mixed team of researchers from different professional backgrounds may be the best way of achieving balanced results.

It is recommended that the surveys be conducted as people (patients and visitors, but not staff) are leaving the department or immediately prior to leaving. For the A&E department this will require some planning as people can leave by several routes: to the wards, to go back home or in those unfortunate cases, to the mortuary.

The depth to which the sampling is done is for the trust or department to specify: for example the split of patients to staff, male to female, the age bands, the days of the week of the survey, and the times of the day or night. The sampling needs to be consistent for both the before and after surveys, although not identical. It is suggested that equal numbers of staff, visitors and patients be

canvassed. It is also suggested that the surveys are conducted at three clearly defined times, such as: one morning, one afternoon and one busy late evening. Clearly if only 20–30-year-old male visitors are surveyed at midnight on Fridays then the results of the survey will be somewhat skewed. A balance should be sought. It should be noted that as few as 100 interviews are sufficient to give a suitably reliable result in each survey run.

What constitutes poor and good standards will be subjective and, therefore, variable. A range of questions, against which each of the 13 factors can be assessed, is given to obtain an element of consistency within the responses.

The facility to be assessed is considered by examining each aspect of the environment and a score between -3 (extremely unhappy) and +3 (delighted) given, with 0 reflecting a satisfactory standard. If a score of -3 or +3 is given, then comments should be requested and recorded on the bottom of the questionnaire score sheet.

The survey comprises 13 questions that address the patient's journey through the department and covers the following areas: -

Access to the site	Internal Comfort
Arrival at the Department	Internal Appearance
Parking	Cleanliness
Reception	Noise
Waiting Areas	Security
Moving Around	Treatment Facilities
Convenience	

During each interview, the results of the survey should be noted on the Questionnaire Cover Sheets and the Questionnaire Score Sheets (one each to be completed per interview). This data should then be transferred onto the appropriate data entry worksheets in the Excel package.

Once the data has been input to the Excel data entry worksheet it is automatically analysed and presented on the chart presentation worksheets as bar graphs showing the findings of the survey. The summary sheet is devised to enable specific aspects of the facility to be considered for different types of visitor. Thus, for example, it is possible to view the data and quality profile charts for male patients under 21 only by switching on or off the required groups using the down arrows on line one of the data entry worksheets.

The process of analysing the input data falls into three stages:

- The first stage survey sets a baseline at the start of the project.
- The second stage recognises the need for improvement in particular areas that may have been highlighted due to scoring poorly in the first survey and sets targets for improvement.

- The third stage repeats the survey to confirm the actual improvements that have been achieved. Were the targets unrealistic, or were they achieved?

Electronic returns to Regional Offices should be made at the ends of the second and third stages, using the Regional Office data return worksheet.

Guidance on interpretation of survey results:

Staff with responsibility for investment and decision-making within the organisation should interpret the results of the survey.

Clearly there needs to be sensitivity to the results of the survey because they could highlight some aspects of your department in a misleading way. Local knowledge and interpretation will need to be added to any reports that are created in order to give a properly balanced picture. The toolkit contains a floppy disc with the following:

- instructions as a Word document
- questionnaire prompt sheets
- questionnaire cover sheet
- questionnaire score sheet
- an empty toolkit within an Excel spreadsheet package
- a worked example within an Excel spreadsheet package

Figure 4 on page 14 shows the toolkit populated by dummy data in order to give an impression of the capabilities and outputs which may be produced.

The chart shows three sets of data collected from the survey merged into a three-dimensional chart, in order to allow comparisons to be made between them. This enhances understanding and allows analysis of the quality profiles, as compared to the agreed performance targets.

Once both surveys have been completed and the target values entered it is possible for senior decision making and investment specialist staff to analyse the data and to come to informed conclusions.

Appendix 3: Examples of tables

Table 3.1 Current property schedule

PROPERTY	USE/FUNCTION	SIZE OF BUILDINGS (sq m)	SITE AREA (hectares)	TENURE	CONDITION	SUITABILITY	UTILISATION	ENERGY PERFORMANCE (GJ/100 cu m)	COMPLIANCE WITH STANDARDS	ESTATES COMMENT
Site Disaggregated by block Disaggregated by portion				Freehold/ leasehold	A,B,C, D,X	A,B,C, D,X	1,2,3,4	A,B,C, D,X	A,B,C, D,X	

Table 3.2 Estate occupancy costs

PROPERTY	RATES	UTILITIES	MAINTENANCE (as defined in ERIC)	CAPITAL CHARGE/ RENT	INCOME (from leases etc)	TOTAL	CAPITAL VALUE (EUV)
Site name							
TOTAL							

Table 3.3 Capital investment programme (at current cost)

SCHEME	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
A	XXXXX	XXXX				
B		XXX	XXXX			
C		XX	XXXXXXX	XXXXXXX		
D		XXXX	XXXXXXX			
E			XXXXXXX	XXXXXXX	XXXXX	
F			XXXXXXX	XXXXXXX	XX	
G			XXXX	XXX		
Backlog maintenance eradication not dealt with through disposals of the above schemes	XXXXXX	XXXXXXX	XXXXXXX	XXXXXXX	XXXXXX	
TOTAL						

Table 3.4 Land and property disposal and acquisition

PROPERTY	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
Disposal site A		–£				
Disposal site B			–£			
Disposal zone 2 site C						
Acquisition car park			+£		–£	
Acquisition land			+£			
Acquisition 2 houses				+£	+£	
etc						
TOTAL						

Appendix 4:

Case studies covering acute and community trust facilities

NB The latter could be applicable to a Primary Care Trust

These case studies, one focusing on a large acute site and the other on a community site, are selected extracts from complete estate strategies. They are designed to show how elements of a strategy can be put together and demonstrate the steps that can be taken to improve performance.

An acute trust

The existing estate

The trust currently has an estate comprising two sites, a district general hospital and a health centre, with a total land area of 32.5 acres, and buildings with a total floor area of 29,500 sq m. Its value in existing use is £30m, and the open market value is estimated at £21m. It can be seen from Table 4.1 that the majority of land and buildings are associated with the district general hospital.

See site plans for each site.

PROPERTY	USE/ FUNCTION	SIZE sq m	TENURE	CONDITION	SUITABILITY	UTILISATION	ENERGY PERFORMANCE	COMPLIANCE WITH STANDARDS
(Name of site)	District general hospital	27,500	Freehold	B and C	Mainly B and C	3 and 4	B and C	B and C
	Health centre	2,000	Freehold	Mainly B	A	2	A	A and B

Table 4.1 Current property schedule of the trust

The estate age profile below shows that a large part of the trust's estate (51%) is more than 40 years old, and this is reflected in the high backlog maintenance expenditure requirement (which can be shown on a separate bar chart).

Tip

A series of pie charts could usefully be included at this point covering the five facets of:

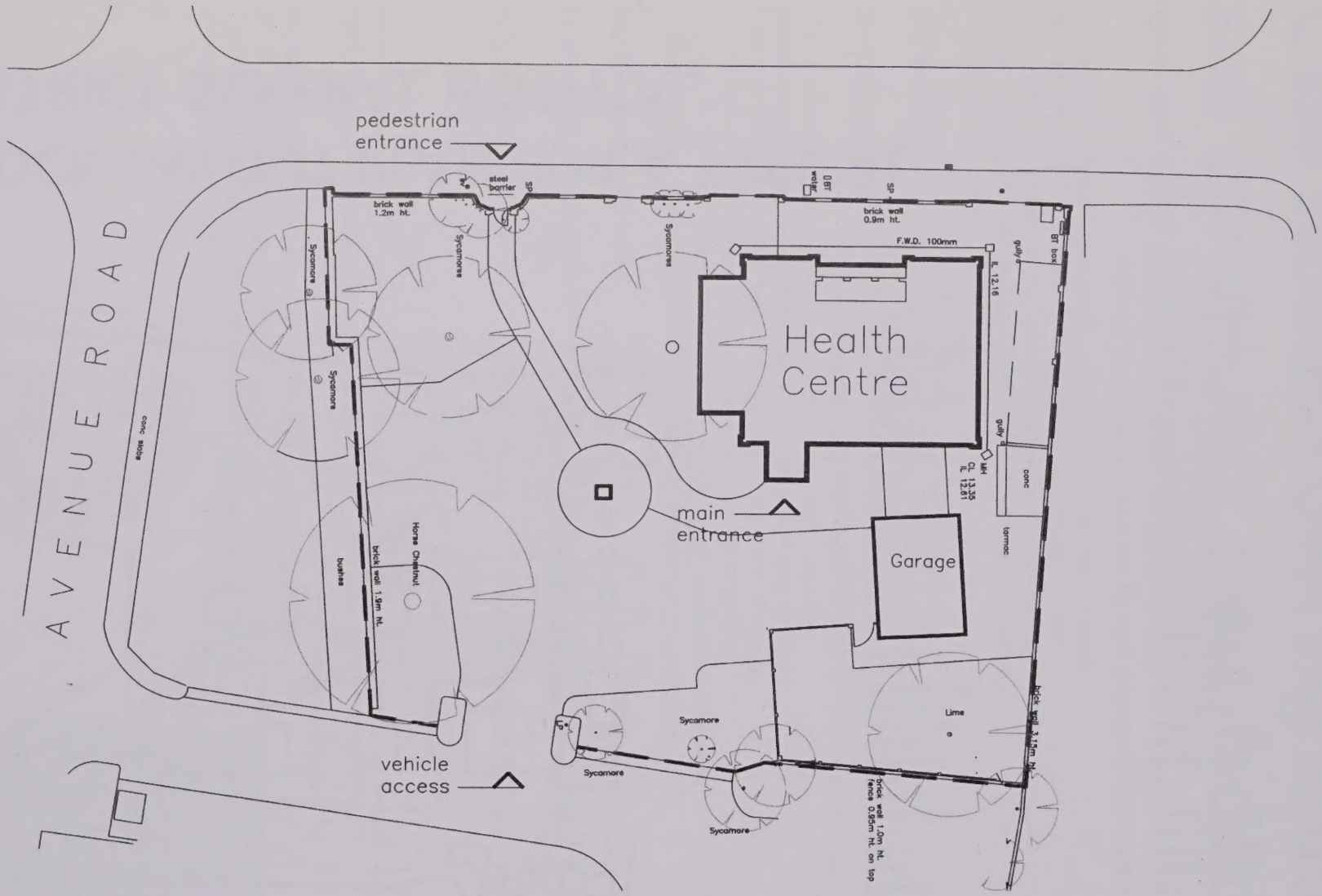
- *physical condition;*
- *energy performance;*
- *compliance with statutory and non-statutory standards;*
- *functional suitability;*
- *space utilisation.*

Examples are included in the main text of this document.

Block reference Key

1. boilerhouse
2. incinerator
3. store 3
4. store 2
5. store 1
6. estates offices
7. mortuary
8. linen
9. maternity gf.
10. maternity ff.
11. maternity 2nd
12. maternity 3rd
13. midwifery school
14. stores
15. main kitchen
16. dining room
17. jackson ward
18. library
19. ward 3
20. anaesthetics
21. ward 2
22. computer centre
23. ward 1
24. switch room
25. ward 8
26. boardroom
27. ward 10
28. ward 11
29. admin/personnel
30. old hospital
31. diabetics centre
34. finance department
38. ward 7
39. day unit
40. gen hv intake
43. safe haven
44. patient info
45. conference
46. nurse home
47. store
48. plantroom ducts
49. operating theatre
50. sterile services
51. accident & emergency
52. x-ray
53. icu
54. day unit
55. ward 5
56. ward 6
57. rehabiltation
58. pathology
59. medical physics
60. pharmacy
61. outpatients
62. opd boilerhouse
63. fracture clinic
65. gas metre
66. garages
67. house 1-7
68. d-residence
69. social club
70. plantroom
71. c-residence
72. gardeners
73. gardeners
74. houses 6-9
75. b-residence
76. e-residence
77. garages
78. a-residence
79. plantroom
80. education centre
81. gas meter
82. radio room
83. chapel

BLOCK LAYOUT PLAN FOR A TYPICAL DISTRICT GENERAL HOSPITAL



EXISTING SITE PLAN FOR A TYPICAL HEALTH CENTRE

A range of key performance indicators for the estate is shown in Table 4.2. The trust's profile is compared to those of trusts with a similar service and estate profile (benchmark group).

Performance indicator	Trust performance	Average	Benchmark group	
			20 percentile	10 percentile
a. income/asset value ratio	0.9	0.95	1.1	1.2
b. expenditure on premises as % total expenditure	6.7	6.6	5.4	4.9
c. ratio of building floor area to site area (sq m/hectare)	2385	2494	2705	3220
d. annual expenditure on maintenance per sq m floor area	16	16	14	12

Table 4.2 Performance analysis

Notes on the trust's performance analysis

a. anything less than a 1:1 ratio usually indicates that the trust should examine how to increase its income or reduce its asset base;

b. the value of this indicator depends on the benchmark cluster to which the trust is compared. It should be of a similar size in beds/income terms and in age of the estate. There is no absolute measure of what is an appropriate spend on the estate, although the NHS in Wales attempted some years ago to define a benchmark figure of 8%;

c. this is a guide to the density of use of sites. Too great a density may indicate a cramped site with inadequate access and parking space; too low a ratio may imply a site in need of rationalisation, the opportunity to dispose of parcels of land, and revenue costs tied up in site maintenance;

d. this is a similar measure to (b) and should correlate to the age of the building, how heavily engineered the building is, and the quality of the technical services and visual environment.

Tip

The use of such performance indicators can be a powerful way to convince board members of the need for an estate strategy.

Proposed changes to the estate

Service changes

Local service and business strategies envisage a significant shift from secondary to primary care over the next decade. The main elements of these strategies that will have implications for the estate are:

a. a downsizing of the district general hospital from 250 in-patient beds to 170 in-patient beds;

b. a 50% reduction in the number of out-patient sessions held on the district general hospital site;

c. the development of a new dedicated day surgery unit on the district general hospital site;

d. the development of a new chemotherapy suite on the district general hospital site;

e. the expansion of the health centre to accommodate increased out-patient sessions and primary care services;

f. the reduction in residential accommodation provided for staff to a minimum of 15 on-call facilities within the hospital.

Key estate performance targets

In addition to the implications for the estate of the above strategy changes, the trust has established key performance targets in relation to the estate:

a. the elimination of all backlog maintenance by the year 2005;

b. to improve the utilisation of space to 90% of floor area being in Estatecode category 3 by 2005;

c. to improve the functional suitability of the estate to 90% of floor area being in Estatecode categories A and B by 2005;

d. to improve the trust's overall energy performance indicator to 60 GJ/100 cu m by 2005;

e. to improve the trust's income-to-asset value ratio to 1:1.2 by 2005.

Estate development control plans

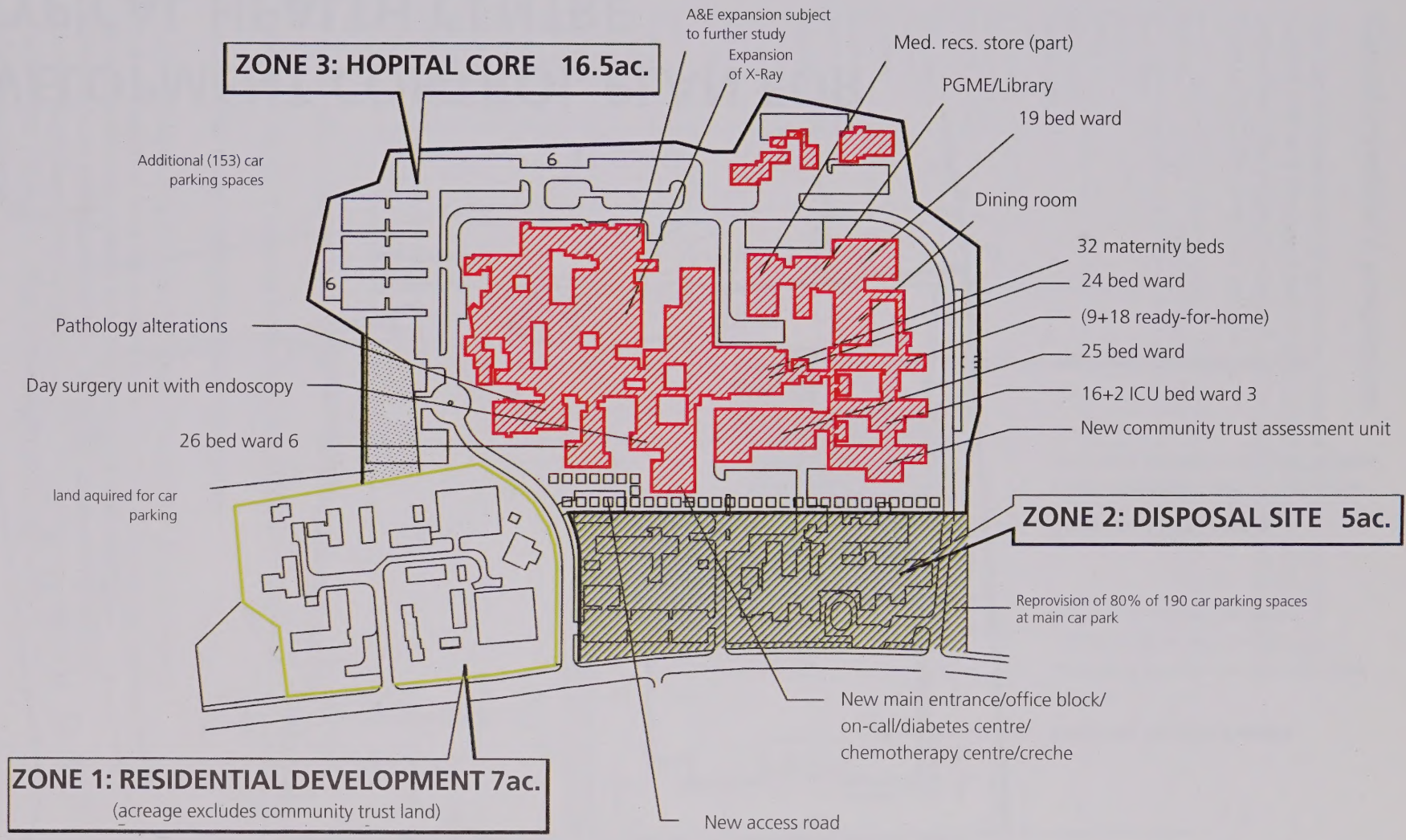
The estate development control plans overleaf show in diagrammatic form the major changes taking place on

a. the district general hospital site; and

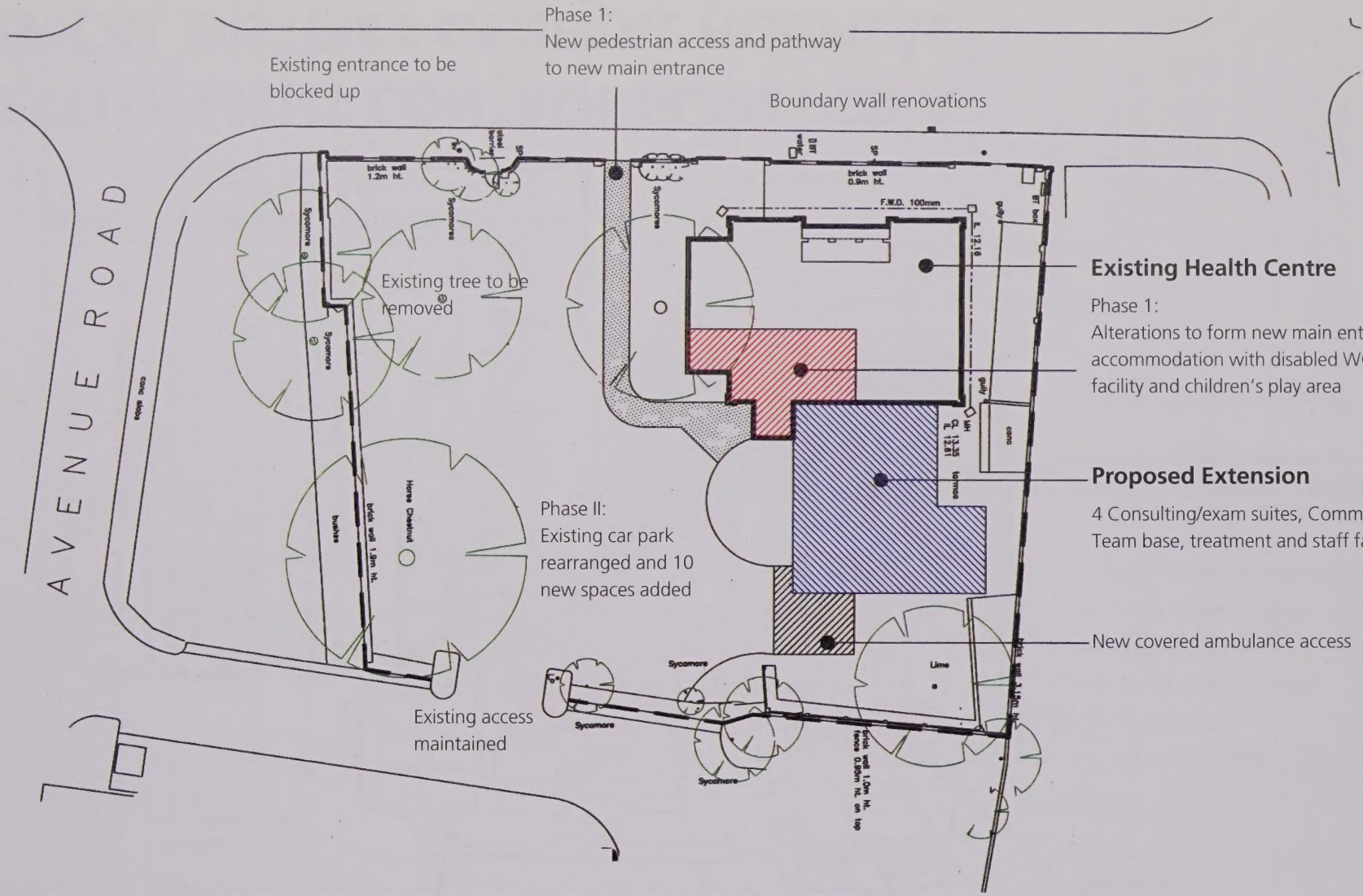
b. the health centre.

It can be seen that the downsizing of the district general hospital resulting from reducing in-patient beds, fewer out-patient sessions and more day surgery, creates a significant opportunity to rationalise the estate. This will enable two sites (zones 1 and 2 on the drawing) with valuable road frontage to be declared surplus to requirements and sold on the open market. The whole of the trust's requirements can be met by the 16.5 acre site shown as zone 3 on the drawing. This has the major advantage of concentrating the trust's usage of floorspaces in the buildings that are currently in the best condition, requiring least expenditure on backlog maintenance.

The development control plan for the health centre shows how the centre can develop into a community facility utilising the existing unused land on the site.


ZONE 3: HOPITAL CORE 16.5ac.
A&E expansion subject to further study
Expansion of X-Ray
Med. recs. store (part)
PGME/Library
19 bed ward
Additional (153) car parking spaces
Dining room
32 maternity beds
24 bed ward
(9+18 ready-for-home)
25 bed ward
16+2 ICU bed ward 3
New community trust assessment unit
Pathology alterations
Day surgery unit with endoscopy
26 bed ward 6
land aquired for car parking
ZONE 2: DISPOSAL SITE 5ac.
Reprovision of 80% of 190 car parking spaces at main car park
New main entrance/office block/ on-call/diabetes centre/ chemotherapy centre/creche
ZONE 1: RESIDENTIAL DEVELOPMENT 7ac.
(acreage excludes community trust land)
New access road

DEVELOPMENT CONTROL PLAN FOR A TYPICAL DISTRICT GENERAL HOSPITAL


Phase 1:
New pedestrian access and pathway to new main entrance
Existing entrance to be blocked up
Boundary wall renovations
AVENUE ROAD
Existing tree to be removed
Existing Health Centre
Phase 1:
Alterations to form new main entrance accommodation with disabled WC facility and children's play area
Proposed Extension
4 Consulting/exam suites, Community Team base, treatment and staff facilities
Phase II:
Existing car park rearranged and 10 new spaces added
New covered ambulance access
Existing access maintained

DEVELOPMENT CONTROL PLAN FOR A TYPICAL HEALTH CENTRE

Capital investment programme

The capital investment programme (Table 4.3) shows the total capital cost and timing of the various schemes required to implement the estate strategy. It can be seen that these equate to a total of £17.28m over the decade.

Scheme	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Refurbishment of ward 2	0.25										0.25
New-build day surgery unit		0.4	0.45								0.85
Relocation of central stores			0.2								0.2
Refurbishment of kitchen		0.1	0.2								0.3
Extension to ward 5				0.2							0.2
New-build chemotherapy unit					1.0						1.0
Installation of CHP plant					0.4						0.4
Extension to Sidcupe Health Centre						0.3					0.3
Car park reprovision							0.2				0.2
Backlog maintenance	0.5	0.5	0.47	0.5	0.5	0.5	1.0	3.0	3.97	1.14	12.8
Medical equipment replacement	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	1.5
Total	0.85	1.1	1.42	0.8	2.0	1.0	1.4	3.2	4.17	1.34	17.28

All cost in millions inclusive of fees and VAT

Table 4.3 The trust's capital investment programme

Notes on the trust's capital investment programme

The table above shows the trust's capital investment programme for the eradication of backlog maintenance. The initial investment will concentrate on the priority area of compliance with statutory standards such as Firecode, COSHH, Electricity at Work Regulations and the Health and Safety at Work etc Act. This will ensure that in year 3 of the strategy all areas of the estate will comply with statutory standards.

The overall investment in eradication of backlog is significantly less as a result of rationalisation of the estate and elimination of buildings with backlog maintenance from the trust's property portfolio.

Land and property disposal and acquisition programme

The programme in Table 4.4 shows the timing of the various land and property acquisitions and disposals required and resulting from the estate strategy. It can be seen that these result in estimated net receipts to the trust of £5.2m. Further work on analysis around timing and value would need to be undertaken.

PROPERTY	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Disposal of DGH – Zone 1 site			–2.8								–2.8
Disposal of DGH – Zone 2 site									–2.5		–2.5
Acquisition of car park land				0.1							0.1
Total	0	0	–2.8	0.1	0	0	0	0	–2.5	0	–5.2

All figures quoted are in £m and are net costs such as agent's and consultant's fees, security and maintenance

Table 4.4 The trust's land and property disposal and acquisition

Tip

Improvements to key estate performance indicators: The strategy should be completed by identifying how the changes proposed will achieve improvements in the performance of the estate against the specific targets that have been set.

A community trust

The existing site

The trust currently has an estate comprising three hospital sites, three health centres and two clinics. It has a total land area of 34.79 acres and a total building area of 42,632 sq m, as detailed in Table 4.5.

PROPERTY	Use/function	Size sq m	Tenure	Condition	Suitability	Utilisation	Energy performance	Compliance with standards
Queen Mary	Sub-acute hospital	17,089	Freehold	B and C	B and C	3 and 4	B	A and B
Downside	Community hospital	10,877	Freehold	B and C	B and C	2 and 3	B	A and B
St Martins	Community hospital	11,176	Freehold	Mainly C	B and D	2 and 3	C	B and C
Health centre A	Health centre	862	Freehold	A and B	A	3 and 4	A and B	A and D
Health centre B	Health centre	1209	Freehold	B	A	3 and 4	B	A
Health centre C	Health centre	898	Leasehold	B and C	B and C	3 and 4	B	B and D
Clinic 1	Clinic	290	Leasehold	Mainly C	B	1 and 3	D	B and C
Clinic 2	Clinic	140	Leasehold	Mainly C	B	1 and 3	D	B and C
Total		42,632						

Table 4.5 The trust's current property schedule

The projected required spend on backlog maintenance/physical condition/statutory standards is as in Table 4.6.

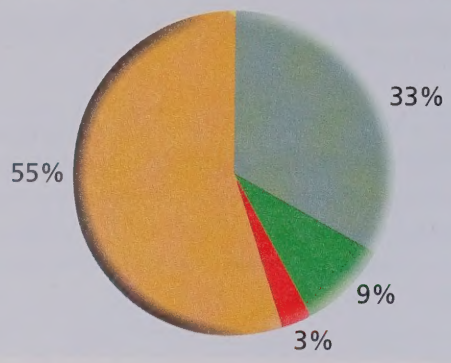
Category		Year 1 £m	Year 2 £m	Year 3 £m	Year 4 £m	Year 5 £m	Total £m
Physical condition	Queen Mary	2.190	1.880	0.130	0.043	–	17.163
	Downside	1.400	1.400	1.100	0.800	–	
	St Martins	2.060	2.060	1.500	1.300	1.300	
Statutory standards	Queen Mary	0.270	0.210	0.023	0.006	–	1.063
	Downside	0.100	0.050	0.036	0.021	0.021	
	St Martins	0.100	0.080	0.076	0.035	0.035	
Fire	Queen Mary	0.120	0.120	0.006	–	–	1.108
	Downside	0.150	0.080	0.026	–	–	
	St Martins	0.200	0.160	0.145	0.101	–	
Total		6.59	6.04	3.04	2.31	1.36	19.33

Table 4.6 Current backlog maintenance total

St Martin's site faces the largest backlog maintenance problem. It requires significant investment over the five-year period to bring it up to physical condition "B2 (£8.22m) and to meet fire safety standards (£0.606m).

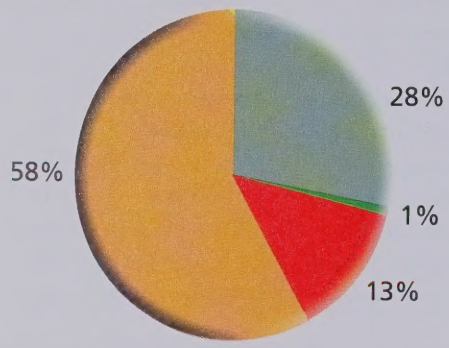
Overall, the trust estate is in poor condition. The following pie charts show the percentage of the estate in conditions A–D against four facets and space utilisation categories 1–4.

Condition by floor area



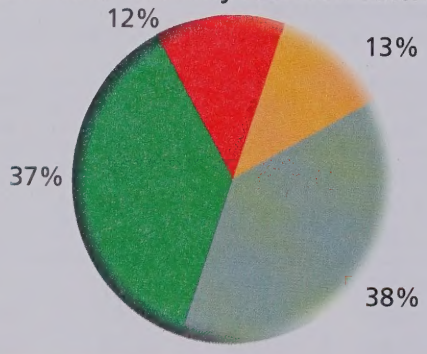
- New to standard Condition A
- Acceptable for use Condition B
- Not acceptable Condition C
- Not acceptable Condition D

Energy efficiency by area



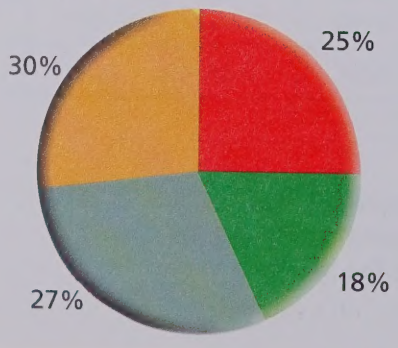
- 35-55 GJ/100 cu m Condition A
- 55-65 GJ/100 cu m Condition B
- 65-75 GJ/100 cu m Condition C
- 75-100 GJ/100 cu m Condition D

Compliance with fire, Statutory and Non-Statutory Standards by floor area



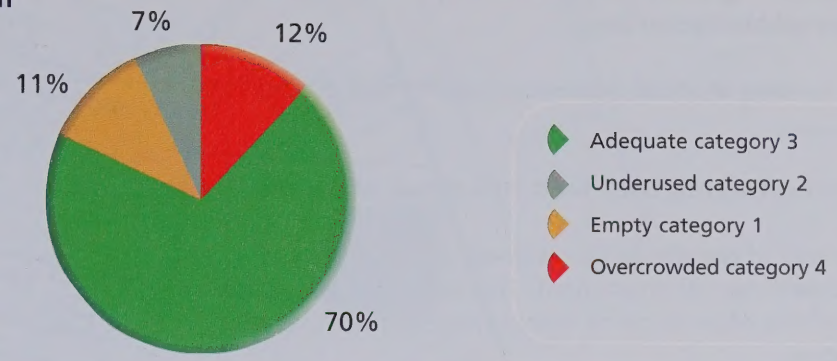
- Complies with Condition A
- OK but minor compliance Condition B
- Serious non-compliance Condition C
- Dangerous Condition D

Functional suitability by floor area



- High deg satisfaction Condition A
- OK but not perfect Condition B
- Not satisfactory Condition C
- Very unsatisfactory Condition D

Space utilisation



The service strategy

The trust has undertaken a detailed review of its assets, and has used this information to contribute to a strategic review co-ordinated by the health authority. It is agreed that patterns of service delivery need to change in order to provide more locally-based services. In addition it is clear that the asset base needs to diminish in order to reduce costs and improve asset utilisation and functional suitability.

The strategy that has been developed is based upon:

a. concentration of acute in-patient services on the main acute site, with locally provided ambulatory services including some day surgery;

b. decentralised provision of medium-term rehabilitation beds for elderly and chronically ill patients, with associated therapy support;

c. development of a model called "enhanced primary care" which encourages primary care-based service delivery and clinical protocols, based on more specialist input from GPs and their teams.

A plan has been drawn up for each of the sites affected as follows:

Queen Mary Hospital

The Queen Mary site faces substantial rationalisation which will halve its size. Peripheral parts of the site will be sold for residential development, and a prime area on one corner of the site is being sold to a superstore. All in-patient services will move to other sites, and the hospital will become an ambulatory care centre. In addition it will house an ophthalmology day surgery unit, an audiology centre and an EMI day hospital.

Downside Hospital

Downside Hospital provides a range of community child health services including child psychiatry, a family planning and sexual

health centre, a community nursing base, a centre for alcohol and drug abuse counselling, a wide range of therapy services, and over 100 elderly care rehabilitation beds.

It is located in an area of social deprivation and is well placed in the town centre.

A health centre has recently been built on a corner of the site.

The plan is for half of the site to be retained, with significant rebuilding and new capital investment. This will reprovide space for the retention of the wide range of ambulatory services that are referred to above.

The model of elderly care that has been agreed involves decentralising rehabilitation beds for the elderly into existing local acute and community hospitals. Thus the in-patient beds at Downside will close, allowing approximately half of the site to be sold.

St Martin's Hospital

St Martin's, as one of the retained community hospitals, needs considerable investment. Out-patient and local community services will continue to be provided from the upgraded out-patient department. The elderly care day hospital will continue to operate from its modern building. EMI beds, which are in a modern block in the centre of the site, will transfer into smaller-scale provision in nursing homes. This will release space to allow elderly care rehabilitation beds to be introduced onto the site. Some new-build will be required to accommodate therapy services. There are four parcels of land that will be available to be sold off in order to fund the new construction. The site rationalisation and planned new development are shown in the site plan and redevelopment drawings that follow.

Matching the estate to the service strategy

Performance targets have been set which aim to reduce backlog maintenance by 80% and to improve the ratio of building floor area to site area. It can be seen from the pie chart above that poor utilisation of space is much reduced once the empty areas are disposed of.

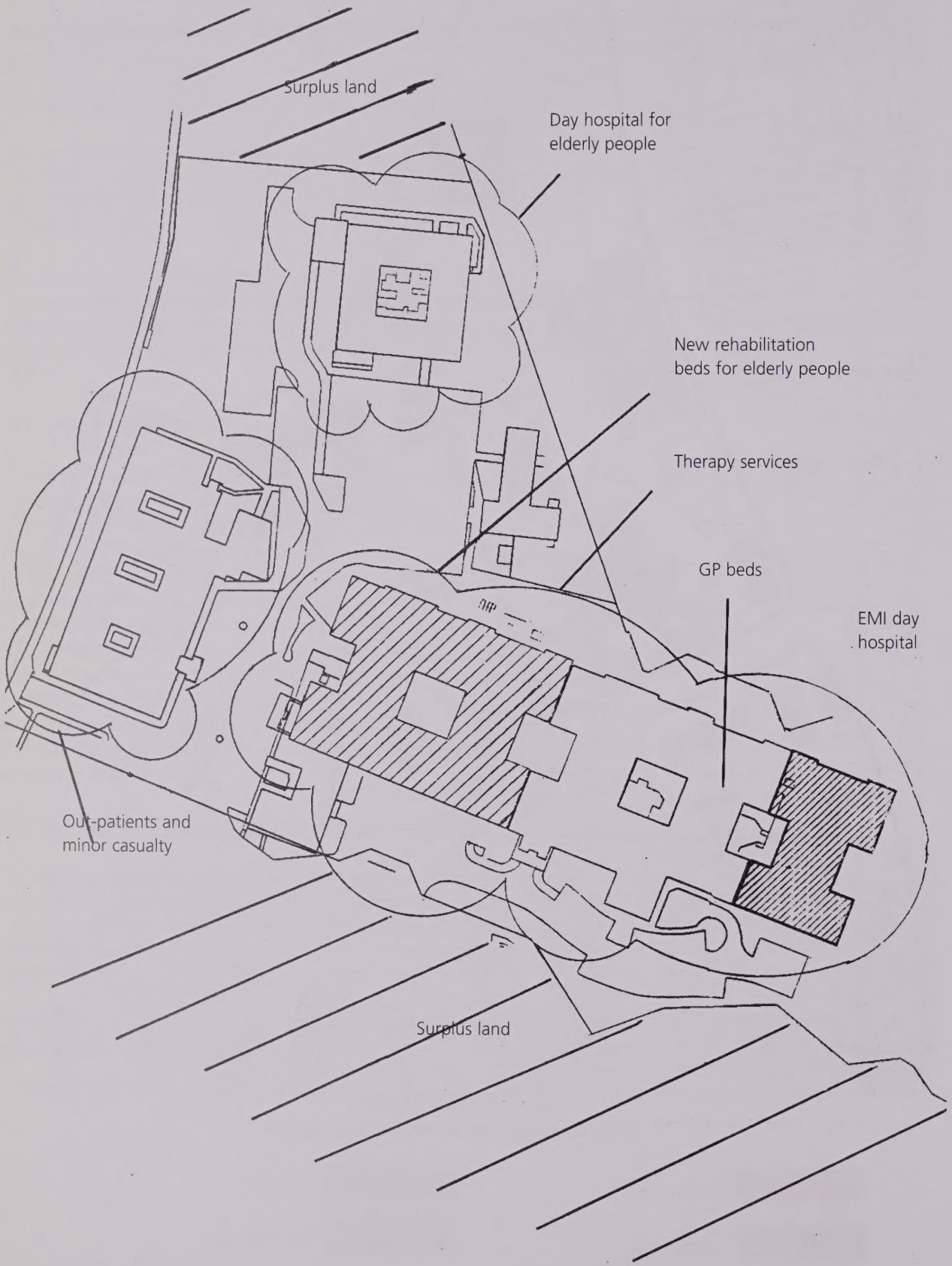
Development control plans have been prepared for each site which set out the major changes planned.

Note

Finally, a capital investment and site disposal programme can be drawn up, which allocates expenditure on priority schemes over a 5–10-year period, and indicates the estimated capital receipts and their timing.

St MARTIN'S HOSPITAL
showing surplus areas and retained portion

St MARTIN'S HOSPITAL
showing redevelopment potential in central retained portion



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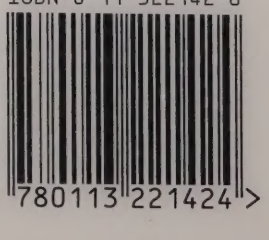
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